



The MODERN HOSPITAL

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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XXX

April, 1928

No. 4

Negro Illness and Its Effect Upon the Nation's Health

By EDWIN R. EMBREE

President, Julius Rosenwald Fund, Chicago

ANYTHING that affects the Negro today concerns the American nation as a whole. One-tenth of our total population is colored. And no longer is the Negro only a resident in the rural South. He has moved north in great numbers and he has gone from the farm to the cities both north and south. About one-fifth of the

Negro population now lives in the northern and western states and a full third of this race is living in cities and towns.

The tendencies toward urban life are seen more clearly when one realizes that the great migration both north and south has been to the largest cities, and that while before 1920 no American



city had more than 100,000 Negroes, six cities had well above that number according to the 1920 census: New York, Philadelphia, Baltimore, Washington, Chicago and New Orleans. An equal number of cities is likely to be added to the group having a negro population of more than 100,000 in 1930, including such rapidly growing centers as St. Louis, Cleveland, Detroit, Birmingham, Ala., and Atlanta, Ga.

The economic and social conditions of a group so large and so widely dispersed cannot but affect intimately the other members of the population with whom they live. This is peculiarly true in the matter of disease. Bacteria have a disconcerting fashion of ignoring segregation edicts. Jim Crow laws have never successfully been set up for the germs of tuberculosis, pneumonia, typhoid or malaria. Many families in the old South most sternly refuse social contact with the Negro, yet live in closest personal association with members of that group who serve as domestic servants and nurses and guardians of children—the very relationships in which disease most easily spreads.

If the white folks take even the most selfish attitude toward the Negro they must from pure self-protection take an interest in his health conditions. That they have been slow to do so is witnessed by the shockingly inadequate facilities for hospital care and community health and even for certain aspects of elementary sanitation that exist for Negroes in this country. And this in a nation and in an age in which care for the public health is becoming almost a religion.

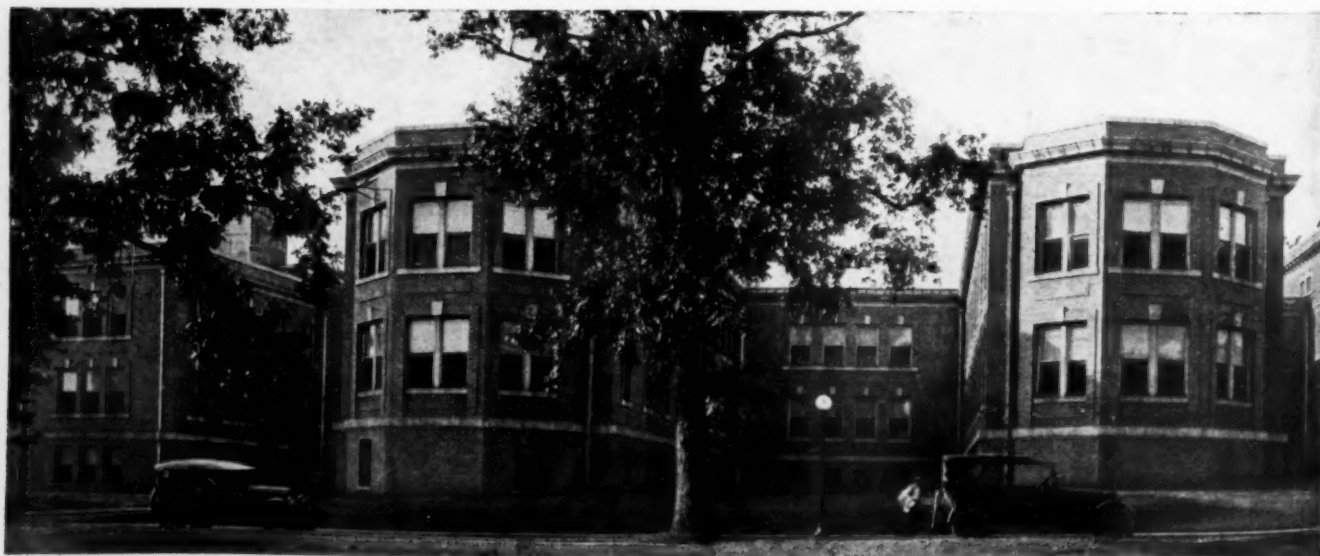
For purposes of analysis it may be useful to consider this matter from the standpoint, first, of what is often technically included under the term public health and, second, of individual hygiene and medical service. The first of these, that is,

public provisions for health, include purification of the water supply, sewerage, prevention of soil pollution and the control of the great contagions, such as malaria, yellow fever and plague, which involve mosquitoes, rats or other animal carriers. These are cared for by governmental and state authorities and, technically at least, protect alike all members of the population. Even then it must be remembered that in certain cities water supply for the Negro section is inadequate and proper sewerage nonexistent and that rural areas inhabited largely by Negroes are often not well protected against disease-bearing mosquitoes and the various types of intestinal parasites.

Negro Hospitals Are Few

It is, however, in the second category, that of individual health and medical service, that provisions for the Negro are largely lacking. Negro hospitals are few in number and inadequate in construction, equipment and financial support. Conditions of housing, nursing service, care of children, pure and proper food and the general community provisions against disease are, among the Negro, inferior to similar facilities for almost all white groups.

These diseases that involve simply human contact, and the control of which is closely tied in to general improvement in community health, are the main problem. These include such ills as tuberculosis, pneumonia, influenza and other respiratory diseases, the venereal group, the ills both to the mother and the child attending childbirth, infant and child welfare, especially care and nutrition of young children, and ailments traceable to teeth. These are the diseases from which the Negro suffers most in comparison with his white neighbor and steps need to be taken to aid him.



Freedmen's Hospital, Washington, D. C., which is supported by Congress

A bulletin issued in February, 1928, by the State Department of Public Health of Illinois gives a striking picture of the difference between Negro and white mortality. This bulletin reports that during the four-year period 1922 to 1925 for the entire state of Illinois the annual death rate among Negroes was 23.0 per thousand as contrasted with 11.2 for whites. According to this bulletin tuberculosis in Illinois causes a mortality of 323 per hundred thousand among the colored, as contrasted with 71 per hundred thousand for whites; the Negro death rate from pneumonia is 330 per hundred thousand, as compared with 73 for whites, and diarrheal disorders take three times as many Negro lives as whites, in proportion to the population.

In fact in Illinois for the period from 1922 to 1925 the number of deaths exceeded that of registered births among the colored people, although the average Negro birth rate for 1925 was 22.5 per thousand, substantially higher than that for the whites. These conditions are not peculiar to Illinois. Wisconsin, Kansas, Minnesota, Iowa, Indiana and Michigan show death rates exceeding or approaching the traditionally large number of births in this group. Conditions in the South where, over a long number of years, the Negro has adjusted himself, show on the whole much better records both for sickness and death.

One should not be too much alarmed by the conditions reported for a few northern states during a period known to be one of transition and of adjustment of large masses of Negroes to new and trying conditions in industrial centers. The current records of the Metropolitan Life Insurance Company, which has on its books more than two million Negroes, a fifth of the total colored population, are on the whole much more reassur-

ing. These policy holders include men, women and children of all ages, working in every conceivable occupation, and living in all sections of the country. Dr. Louis I. Dublin in a recent article* reports, from the extensive experience of that company, that the average death rate of these two million policyholders has declined from 17.5 per thousand in 1911 to 14.6 in 1926. While in a sense the insured are a picked group, still the large number included makes the findings significant. Dr. Dublin's study indicates that Negro health has greatly improved during the past few decades, that it is in about the position of white health in this country thirty or forty years ago, and that further concerted and intelligent attack may be expected to show corresponding gains in years ahead.

Are Negroes Increasing?

Two things may be said about trends in the colored population in America. However bad conditions are in given localities there is no evidence that the group will die out or even diminish in number. On the other hand there is no likelihood that the Negro will increase at any rapid rate or begin to press the white man by sheer force of numbers. As a matter of fact, while the colored population of America has steadily increased in numbers since the first arrivals from Africa, it has for over a century quite as steadily decreased in proportion to the total population. The following table, from the official census figures, gives a

*Recent authoritative publications on Negro health include chapters in two books just off the press: *Negro Problems in Cities*, T. J. Woofter, Jr., Doubleday, Doran and Company; *The American Race Problem*, E. R. Reuter, T. Y. Crowell; and the following papers: *Life, Death and the Negro*, Louis I. Dublin, *American Mercury*, September, 1927; *The Death Rate Among the American Negroes*, James A. Tobey, *Current History*, November, 1926; *The Negro Health Problem*, Frederick L. Hoffman, *Opportunity*, April, 1926; *The Tuberculosis Problem and the Negro*, H. R. M. Landis, *Virginia Medical Monthly*, January, 1923. The annual volumes of the *Negro Year Book* also give much general and statistical information.



This hospital is the teaching hospital of the Medical College of Howard University

clear picture of the relation of the Negro to the total American population during the history of the nation:

Year	Colored Population	Decennial Increase Per Cent	Per Cent of Total Population
1790	757,208	19.3
1800	1,002,037	32.33	18.9
1810	1,337,808	37.50	19.0
1820	1,771,656	28.59	18.4
1830	2,328,642	31.44	18.1
1840	2,873,648	23.40	16.8
1850	3,638,808	26.63	15.7
1860	4,441,830	22.07	14.1
1870	5,392,172	21.35	13.5
1880	6,580,793	22.05	13.1
1890	7,488,676	13.80	11.9
1900	8,833,994	18.00	11.6
1910	9,827,763	11.20	10.7
1920	10,463,131	6.50	9.9

The Negro, as any other group in the population, begins to have smaller families as he rises in the economic and social scale. Better public health has not brought a great onrush of population among the whites in America and it will not do so among the colored. Fewer and better babies seems the established rule as prosperity, intelligence and health increase. As we begin to set greater value on human life we become more thoughtful to preserve existing lives and we also become more careful about assuming the serious responsibilities of bringing new lives into being.

Death is not the only index of health. While figures that will show the amount of sickness are much more difficult to obtain than those for deaths, it is evident that the higher death rates by no means tell the entire story of Negro health handicaps. Sickness in both mild and acute forms is known to be much greater among the colored people. Incapacities due to accidents and painful illness and malformations due to improper medical attention are conspicuous in this group.

Let us look for a moment at the actual facilities reported in the single field of hospitals. Although facts concerning them are by no means an infallible index of Negro health, they are the visible and material evidences of medical service to maintain that health. A list recently compiled by the National (Negro) Hospital Association reports approximately two hundred institutions throughout the entire country including regular hospitals, infirmaries, and sanitoriums, taking into account institutions supported by public authorities, by fraternal organizations, and private endowment or subscription or as the personal projects of individual physicians or groups of physicians.

While the total figure is sufficiently small, the

picture is not seen at all until the conditions of most of these hospitals are kept in mind. Only nine of this total number are on the accredited list of the American Medical Association as proper institutions for the training of interns, and only fifteen are on the list of the American College of Surgeons as having adequate minimum hospital standards. This means that less than twenty hospitals for Negroes exist in the entire country that are of acceptable minimum American standards.

It should be said in order to avoid any possible misunderstanding that the Negroes themselves are not responsible for the existing conditions. In fact leaders among them have been struggling against great odds to improve things. But while they have been furnishing probably more than their quota of the labor of the country, they are still lacking in individual or corporate control of capital. The small number of Negroes who are now becoming prosperous are subscribing, probably beyond the average in America, to various aspects of social welfare, including hospitals, but relatively speaking there is little money in Negro hands. Furthermore the tax funds are still almost exclusively controlled by white groups. With few exceptions, small sums indeed have gone from Government sources to hospitals. The situation will be corrected as colored people get increasing wealth and as white groups that benefit both by Negro labor and by Negro taxes meet their fair share of the load.

Fortunately several of the acceptable hospitals that are available for Negroes are of excellent quality. They stand out as beacons toward which Negro hospitalization as a whole is struggling.

A Center for Research

An important institution is Freedmen's Hospital, Washington, D. C., supported directly by Congress and serving as the teaching hospital of the Medical College of Howard University. This excellent hospital is kept in a good state of improvement and equipment. It has a total of 278 beds, provides internship for twenty-eight colored medical graduates, maintains an excellent school for nurses, and is a center for medical teaching and research.

George W. Hubbard Hospital, Nashville, Tenn., with 140 beds, similarly serves as the teaching institution for Meharry Medical College. Plans are now under way for moving this hospital and the Medical College to land immediately adjoining the campus of Fisk University. On its new site with increased resources, which are confidently expected, this will become a great hospital and medical center. At present these institutions in

Washington and Nashville are the only ones that combine good hospital facilities with excellent medical school standards. Their influence on medical education and on hospital and nursing development is of the greatest significance.

Several other hospitals are of high standard both in care of patients and in facilities for interns and nurses, although they lack the medical school connections that make Freedmen's and Hubbard preëminent.

New York City has two hospitals in the front rank. Harlem Hospital, with 348 beds, a part of the municipal system, is one of the leading hospitals from the standpoint of the care of patients and of nurses' training. Unfortunately it is lacking on the side of facilities for colored interns. The classic school for the training of Negro nurses is that affiliated with Lincoln Hospital. The hospital itself, now under city auspices, serves, with its 450 beds, chiefly a white community and is staffed by white physicians. The nursing school has for years been of first rank, and under a new arrangement the endowment, built up over a number of years, continues under a special board of trustees, to be available for the support in perpetuity of a school for nurses for colored girls.

Hospitals for Negroes under the regular municipal system exist also in St. Louis and Kansas City Mo.; the St. Louis City Hospital No. 2, of 275 beds and Kansas City General Hospital No. 2, of 200 beds. This movement to have Negro hospitals supported directly by the city treasury is significant. It may be one of the natural approaches to more adequate support for colored hospitals. When tax funds can be adequately counted upon for building and maintenance of these institutions then their financial future is assured.

A striking hospital development in Baltimore points the way to cooperation between Negroes and whites, both in finance and in medical service. A group of physicians associated with Johns Hopkins led by Dr. J. M. T. Finney recently joined with the Provident Hospital, Baltimore, to raise both funds and standards. The building is being completely remade and repaired and adjoining property has been purchased for a nurses' home and for future building. The campaign was started for \$175,000 and more than twice that amount was raised, in total somewhat over \$375,000. Of this \$25,000 each was given by Julius Rosenwald and John D. Rockefeller, Jr. Over \$170,000 was raised by Negroes in Baltimore, almost entirely from among their own people, and \$160,000 was raised by a white committee. The group of white physicians will serve as consultants and will take direct personal responsibility for helping to keep the standards of medical

care and of training for nurses and interns at a high level. This is a notable demonstration of what can be done when a concerted effort is made under able leadership. The contributions of the colored group are little less than epoch-making.

Mercy Hospital, Philadelphia, with 100 beds, not only is doing a good work, insofar as its limited facilities will allow, but has an excellent informal arrangement whereby members of its clinical staff and of its school of nurses serve with the Phipps Clinic in out-patient work and in home visiting in the thickly populated Negro section of this city. Another hospital in Philadelphia, the Frederick Douglass, with 100 beds is also on the accredited lists of the American Medical Association and the American College of Surgeons.

In Chicago the Provident Hospital, in a sub-



Flint-Goodrich Hospital, New Orleans, La.

stantial brick building, erected nearly forty years ago, continues to do good work. Sixty-five beds provide facilities for a number of private patients, as well as for groups in wards. Dr. G. C. Hall and a group of Negro physicians are giving good service to patients although the necessarily high charges keep the daily census rather low. Facilities are offered here for the training of interns and nurses.

In the far South the Flint-Goodridge Hospital, New Orleans, has been making heroic struggles against great odds. Sixty-five beds in an old building have served a part of the colored community in New Orleans, and this service has extended far beyond the hospital walls by progressive developments in the form of out-patient clinics, prenatal care, and home visiting. Here plans are taking shape for rebuilding on a new site.

The Charity Hospital, Savannah, Ga., is another of those that has been maintaining standards against every handicap and that is also planning an entirely new plant.

The Dixie Hospital of sixty-five beds in Hampton, Va., while not a part of Hampton Institute stands on property immediately adjoining and may be expected to have even more intimate association with the institute as years go on. Plans have been discussed for a combined course looking toward academic work and nurse training, to be carried on jointly by the institute and the Dixie Hospital. The John C. Andrews Memorial Hospital, Tuskegee, Ala., a hospital of seventy-five beds, is directly associated with the Tuskegee Institute. These hospitals, in conjunction with these two historic schools, may play an increasingly important rôle, particularly in the field of nurse training. The St. Agnes Hospital of 100 beds, Raleigh, N. C., affiliated with the St. Augustine School, and the McLeod Hospital, Daytona Beach, Fla., connected with the Daytona Industrial School in Florida, are also making heroic attempts, although with much less adequate facilities than those at Hampton and Tuskegee.

The Burrell Memorial Hospital, Roanoke, Va., has made notable improvement in recent years. It is said now to have better medical records than any other hospital in the city. St. Philip's Hospital, Richmond, Va., with 176 beds, is one of a group controlled by the hospital division of the Medical College of Virginia. It is not practicable, nor would it be fair except on the basis of an extensive survey, to attempt to print here a list of Negro hospitals that were thought to have adequate minimum standards. In addition to those listed above I happen to know something of the work and standards of the following hospitals: People's Hospital, St. Louis, Wheatley Provident Hospital, Kansas City, Mo., Lincoln Hospital, Durham, N. C., and the Millie E. Hale Hospital, Nashville, Tenn.

Facilities Available for Colored Patients

In addition to hospitals exclusively for Negroes or under Negro management there are in many places other facilities for the care of colored patients. Many of the municipal and county hospitals of the northern cities have a large number of Negroes in their wards. The large Cook County Hospital, Chicago, and the Philadelphia General Hospital, Philadelphia, are said to be often more than half filled with colored patients who are accepted without discrimination. In the South many of the general hospitals, as notably the Charity Hospital, New Orleans, have wards that serve many Negro patients. While these services

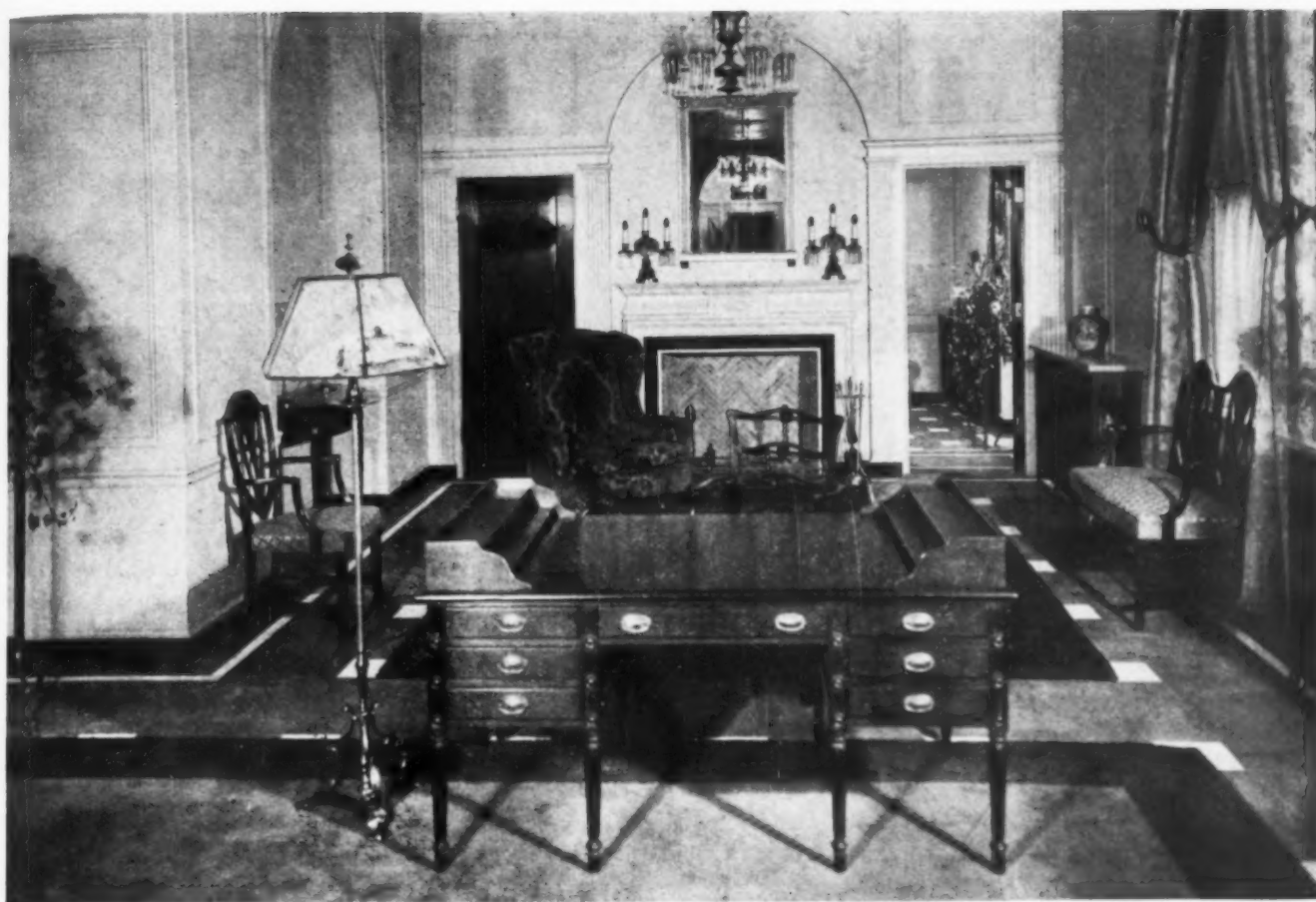
are of benefit to the sick they do not, save in exceptional cases, offer any facilities for the teaching of Negro medical students, for service by Negro physicians or for the training of interns and nurses of the race. Most hospitals for white patients, however, have no facilities whatsoever for Negroes.

Hospitals have been discussed at some length because, as I have said, they are the visible and material evidences of medical service. They by no means represent all the facilities needed in a well rounded program of health. In fact, except as bases and training grounds, hospitals are less important in the present day aggressive combat against disease than certain other arms; out-patient clinics for mothers and babies and for general work, visiting and public health nurses, and public health protection against pollution of water, food and soil, and against animal and human carriers of disease. The lacks in hospital facilities unfortunately are simply typical of equal lacks in these other aggressive branches.

Training for Colored Nurses Needed

In this paper I have attempted simply to state a few of the salient features of the problem regarding hospitals and health for Negroes. The facilities for institutional care and health protection are shamefully inadequate and this fact is reflected in unfortunate death rates and in a great amount of sickness and distress, not only among Negroes but, as a result, among their white neighbors. Any constructive program must include not only more and better hospitals but also a good organization for visiting and public health nursing, for practical instruction in the schools, and for aggressive out-patient services and clinics, which will emphasize preventing serious illness by checking it in early stages, thereby protecting the home and community. One of the prime needs is for extension both in numbers and in quality of the training of colored girls for nursing, particularly in its public health aspects, and the use of these nurses in clinics, schools and rural counties and city homes.

Happily there is evidence of renewed interest in the whole matter. The national medical, surgical and hospital associations have been conferring with the Negro Hospital Association concerning possible studies and standardization. Nursing associations have been discussing their aspect of the problem. One of the great Foundations has given substantial help to Howard and Meharry Medical Schools, and other Foundations and individuals are displaying active interest. Another decade should see great progress in America in hospitals and health for Negroes.



Beauty Is Another Asset

By S. D. HUNTER

Superintendent, Washington Hospital, Washington, Pa.

THE witch doctor of the upper reaches of the Ozone River knows well the therapeutic value of the bitter potion. It must not only be bitter but disgusting, as well. Shakespeare aptly recognizes this early stage of medicine in Macbeth:

"Fillet of a fenny snake,
In the cauldron boil and bake;
Eye of newt and toe of frog.
Wool of bat and tongue of dog.
Adder's fork and blindworm's sting.
Lizard's leg and howlet's wing.
For a charm of powerful trouble,
Like a hell-broth boil and bubble."

If the case were very serious and the patient of sufficient social standing, the witch doctor presented the beating of tom-toms through the night and day to frighten the evil spirits away. (The tom-toms of savage medicine have their counterpart in the hospital, but that's a subject for another day). The modern pharmacopeia, too, recognizes the value of the bitter potion. To one

well steeped in the realities of an Iowa farm, castor oil disguised in orange juice is almost as sacrilegious as denying the infallibility of the Republican party.

Some people must be miserable when they are sick if they are to get the greatest enjoyment out of it. They must have bitter medicine, dolorous friends and unpleasant surroundings. While such persons are in the minority, it seems that most of our hospitals have been furnished with an eye to their pleasure. How many hospital rooms are there into which anyone with a sense of beauty, of the fitness of things, of color, might enter without a shudder? Drab walls, ugly furniture, atrocious draperies are found in the average room or ward.

But beautiful things, it is said, are not practical; they won't wash; they are expensive. This is far from the truth. Furniture that is both beautiful and practical may readily be had; draperies that are colorful, sun-fast, washable and inexpensive are readily obtainable. And paint



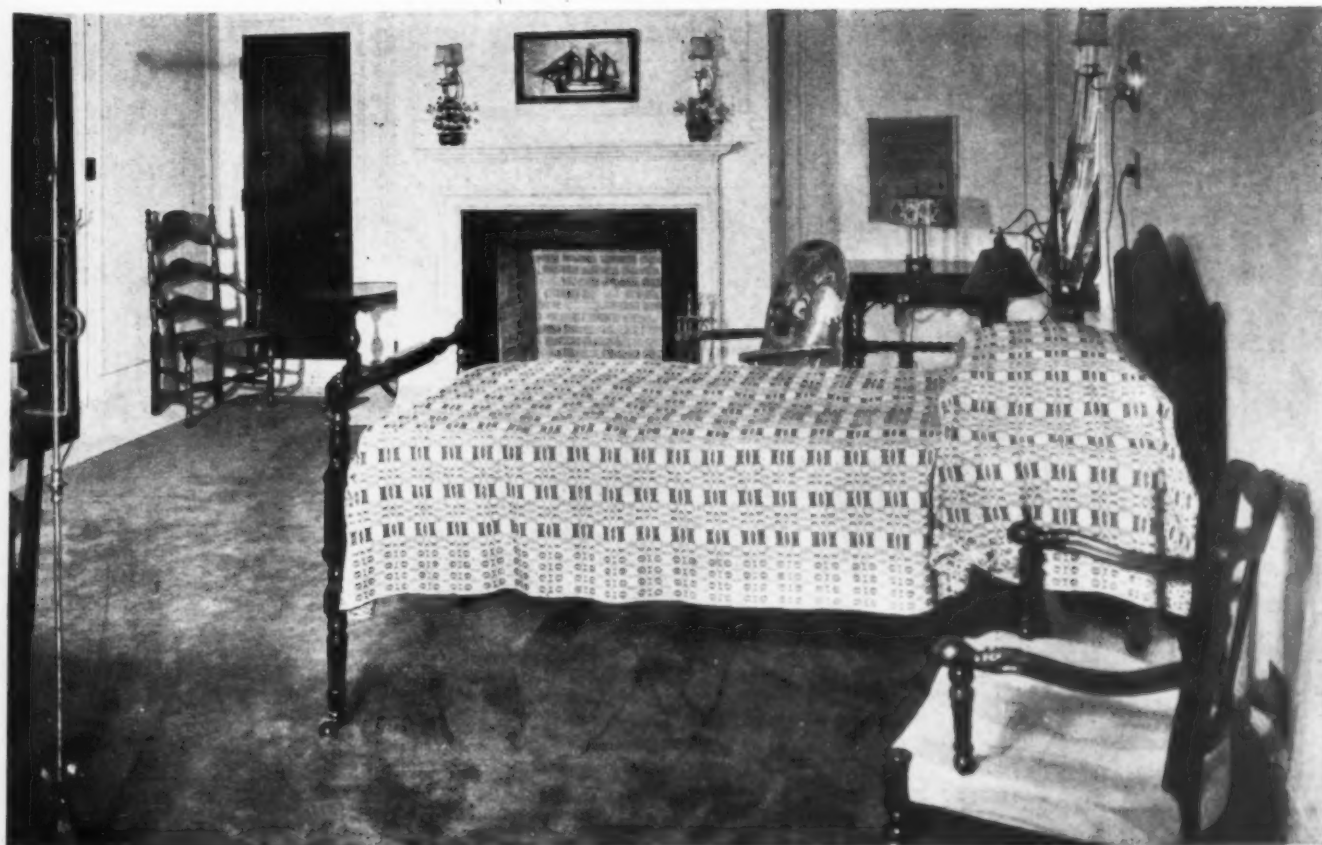
On the left is shown one of the de luxe bedrooms, carried out in early American furniture. Chintzes of good designs and gay colors are used for upholstery.

Below is a visitors' alcove, of which there is one on each floor. Attractive curtains are at the window.



In the solariums, one of which is shown on the right, are to be found comfortable, substantially built lounging chairs. Up-to-date lamps and shades are noted.

Below is another view of one of the de luxe bedrooms. On the wall appears an old-fashioned sampler.





The nurses' dining room is shown above. The room is well lighted with many windows and is made attractive by ferns in tall stands.



On the left is shown a corner of the reception room. The furniture here is such as might be used in any private home.

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The children's play room has attractively decorated walls and is equipped with a fine assortment of toys. It fronts upon the porch.

Here is a third view of the bedroom shown on the preceding pages. These rooms have a private bath, shower and alcove, and are of good size.

costs no more in apple green, or some other pleasing color, than in that mustard color euphoniously called "buff."

I remember well the refreshing shock I received while examining the new section of an old hospital in a none too attractive part of New York City. Wires for carrying curtains to separate the beds in the wards had been provided, but instead of hanging the usual dirty-white curtains, the superintendent had the originality and courage to use pastel pink curtains against a yellowish cream wall, relieved by three or four potted ferns. A ward, none too well lighted, was thereby transformed from bleak dismalness to a thing of joy—of life. Did the patients like it? The few that I talked to said they did. Did they get better any quicker? No one knows, but if the sparkle of color relieved for but a few moments the bleak monotony of the wards for a few patients during the year, it was well worth while. Those who weren't cheered (unconsciously perhaps) by the lovely color were too far sunk in apathy to be affected by their surroundings.

Call in a Decorator

This daring innovation was inspired by a superintendent, and probably 50 per cent of the banal results of hospital furnishings can be laid directly at the door of the unimaginative hospital superintendent. The other 50 per cent may be attributed to the Ladies' Aid Society. What every hospital, new and old, should have is the assistance of a decorator with experience, daring and sympathy. For instance, turn the decorating and furnishing of the new Columbia-Presbyterian Medical Center, New York, over to Urban, who has so successfully furnished stage decorations. The result would be worth going round the world to see—maybe.

All of this is an introduction to a story about the furnishings of the Washington Hospital, Washington, Pa.—a story told in pictures. The pictures lack one element—that of color. It is, however, in reality, present in abundance.

Whether you like these furnishings or not will depend on your temperament. If you are one of those who believe it is wicked to sit in a cushioned pew at religious services—you won't.

The hundreds who have been patients in the Washington Hospital since its opening last spring are unanimous in their praises. Many of them had been patients in the old hospital, or in other hospitals furnished in the old drab manner.

We know that the average stay of the patient in this hospital has been shortened two days. Our modern equipment may partly account for part of this, but we feel that the result is largely due to cheerful surroundings.

Capitalizing Criticism

By F. STANLEY HOWE

Director, Orange Memorial Hospital, Orange, N. J.

Is it possible that hospitals are too sensitive in the matter of criticisms to turn them to advantage?

Our president recently called me on the telephone in deep distress. The report had reached her that our dietary standards had fallen off and that considerable dissatisfaction was finding its way into the community. She and the chairman of the domestic committee announced their desire to see me to discuss this serious situation.

Determined to find out what, if any, was the basis of such complaints, a neatly printed questionnaire was prepared and placed upon the tray of every adult patient, ward or private, at breakfast the following Sunday morning, reading as follows:

ORANGE MEMORIAL HOSPITAL

Dietary Department

It will be of the greatest help to this department to have your very frank comment or criticism on the food served to you in this Hospital. Your replies to the following questions will be deeply appreciated, whether favorable or otherwise.

Florence E. McKenzie, Dietitian.

Name of Patient
Building Floor Room
Is the food served satisfactory?
If not, in what respect could it be improved?
If you have been a patient in this hospital before, how does the food compare with what you had then?

General Comments or Suggestions:

.....

This referendum brought to my desk on Sunday afternoon 108 signed replies. Of these, three said the food was not satisfactory, three qualified their answers and 102 stated without equivocation, and many with marked emphasis, that the food was satisfactory. A number of comments, suggestions and constructive criticisms that were offered bore clear evidence that the patients had taken the matter seriously and had endeavored to be helpful.

The delegation waited upon me on Monday. The patients' replies were placed in their hands, completely reversing the state of mind previously existing, with a result that our whole board is now ready to defend our dietary department against all comers. The daily papers serving this community gladly gave space to our account of the referendum and its results, together with some general statements on the problems of a hospital in satisfying everybody with the food.

The suggestions that were made have directed the dietitian and her staff to a few weak spots in the service, with prompt and favorable results, but in general the effect of this method has been to stimulate the department to maintain and improve standards, while at the same time stifling an undercurrent of criticism that could do little but discourage.

The important point, however, is that where conditions are as they should be, meeting criticism with facts clearly and cheerfully stated will convert many a knock into a boost.

I commend this method to others similarly situated, in the hope that they may get as encouraging results.

The O. P. D.—Where Clinical Efficiency Is Best Acquired*

By JOSEPH BRENNEMANN, M.D.

Winnetka, Ill.

I HAVE always been interested in out-patient work fully as much as in ward work, in some ways more so. I have, moreover, never been able to understand why other clinicians have not felt the same way about it.

My own attitude can probably be attributed to the fact that I belong to that somewhat older school of clinicians who still feel reasonably confident that they can make an accurate, scientific diagnosis without the aid of a laboratory, except in the occasional case. I do not hesitate to say that I believe that is the proper attitude to have toward the matter; that the best and most useful clinicians have always had, now have, and always will have that attitude.

I would say, further, that the prevailing tendency exemplified in the big "once over," in which all of the history, past and present; all of the signs and symptoms; all of the special laboratory tests, are gathered on the desk and pieced together into a diagnosis as one would piece together a cut-out puzzle, must inevitably lead to diagnostic atrophy and impaired medical efficiency. To change the metaphor, it is as if someone else caught the fish, identified the species, weighed and measured him, firmly inserted the hook, drew the line taut and then asked me to pull him in. The real fun in clinical medicine, the real training in the great art of practicing medicine, lies in the attempt to evaluate a case from the patient himself without even a history, as does every good

dermatologist; asking only such questions as are necessary; resorting finally only to such special tests as are essential for corroboration and demonstration, and occasionally for further information. The intern who tells me a diagnosis before I see and examine the patient is very new, and never does it a second time.

A Changing Viewpoint

THERE are still many who marvel that anyone, especially an older clinician, can speak with enthusiasm of dispensary work. There are encouraging signs that that attitude is changing. How can the change be hastened and made more complete? In several ways. The younger man must not only be told, he must not only be shown, he must see that there is no more valuable and interesting work anywhere in medicine than the work done in the out-patient department. Nothing contributes more to this than a knowledge that he can at all times have free and immediate access to eager and sympathetic consultation with older men who have had a wider experience and can see more from that point of vantage. He thus remains a student and not a drudge.

The purport of all these remarks is this: To acquire a high degree of clinical efficiency of the kind, and by the method, indicated, requires constant practice. While we can and do use this method of attack in the wards, it is in the out-patient department that it reaches its highest degree of development and of usefulness; it is here in its natural element.

Nowhere else can the younger clinician see so many patients in so responsible a capacity. They follow one another in fairly rapid succession, and a decision must be reached and recorded in ink, then and there, in the presence of parents and relatives and perhaps other clinicians, who all have embarrassingly retentive memories. They present, moreover, not the classical, textbook pictures that one meets in the wards, where nine out of ten cases can be diagnosed with precision by a senior medical student, if you give him time, laboratories, and a good textbook. They are largely indefinite things, often tantalizingly so, with abdominal pain or diarrhea due to a throat; meningeal symptoms due to an ear; pain in the knee due to a hip, or just above the ankle due to a scurvy; or, worst of all, with a high fever and nothing to put one's finger on, and an anxious

*Read before the Children's Hospital Association of America, Minneapolis, Minn., Oct. 12, 1927.

mother to appease. And that mother, and if she happens to be Italian, likewise a host of volubly inquiring relatives, have a pedagogic value that is second to none and that has no counterpart in the wards.

It is in the out-patient department that one gets, moreover, a real cross section of what is going on medically. The man who works only in the wards, especially the full-time man, not only has no idea of the relative incidence of disease but he is by that fact deprived of one of the most important diagnostic aids, the law of probability.

Keep the Well Child Well

The unique pedagogic value, too, of the out-patient department as compared with the wards in the great and increasingly important modern field of prophylaxis—the keeping of the well child well—needs only to be mentioned to be appreciated.

In the light of all this it has always seemed strange to me that clinicians, even beginners, still look upon dispensary work as drudgery, as a sort of hired-man-working-for-the-boss-in-the-wards job, with an eye and a hope on the boss's real job in the near future. The fault cannot lie in the out-patient department itself—it must lie in the manner of conducting and utilizing it. I believe we have been able to demonstrate this fact to a convincing degree at the Children's Memorial Hospital, Chicago.

To make an out-patient department efficient and inviting along the lines indicated requires four things: (1) a proper number of patients; (2) an adequate physical equipment; (3) a suitable organization, including enough clinicians, nurses, social service workers, volunteer workers, students, records and a librarian; (4) an all-embracing, ever present esprit de corps.

All of these things will, of course, vary with the size of the hospital; with the amount of money available; with the nature of the institution, whether wholly, part, or not at all charitable; with the nature of the staff, whether full-time, part full-time or wholly non-full-time; and lastly, whether the hospital is isolated or immediately adjoining and integrally a part of a medical school. I shall have in mind chiefly in this discussion an institution such as ours, a large children's hospital, almost wholly charitable, and with no full-time men.

By a proper number of patients I mean not too few and not too many. If there are too few, interest lags and time is wasted. If too many, both clinician and patient suffer. Ten or twelve patients would seem a maximum per clinician for

a two-hour period. If there are enough attending men a smaller number is better, so that there can be freer consultation, demonstration and discussion. Some years ago I visited the out-patient department of one of the largest and best known European children's hospitals. There were two clinicians, and 500 patients were received in one morning—sick patients. It was a ghastly, unforgettable experience. The clinicians got little out of it, the patients much, much, less.

With a staff of about sixty-five men, nearly all of whom do some out-patient work we have about the right number for a hospital of 250 beds, and for an out-patient department of about 35,000 visits a year. It is our constant aim to keep children out of the hospital, rather than to run them in simply because they are sick or interesting. We do this for several reasons. The great majority of patients fare better in the home and in the out-patient department than they do in the hospital; it enhances the interest, and so the value of the out-patient department, other things being equal, not to rob it of interesting and instructive cases that do equally well there, and can be used there for teaching purposes; we have, furthermore, unceasingly in mind that every child is a constant candidate for contagion; and, lastly, it is about five times as economical.

Baby Benefits Most in O. P. D.

All of this is especially true of the baby. He can be carried to the clinic for an illness that would exclude an older child or an adult. The menace of contagion reaches its maximum in the baby; not of the conventional contagious diseases, but of that ever dreaded modern "captain of the hosts of death," grippe, or throat infection, or respiratory tract infections, or whatever else you may choose to call it. It is no lighthearted, care-free experience to send a baby into an infant ward with some minor but pedagogically interesting ailment and have him die of an acquired bronchopneumonia, on the one hand; or, on the other hand, to have a baby with a grippy infection admitted to a ward, and have him spread death and destruction about him. The death certificate from the infant wards now commonly reads "bronchopneumonia," not "gastro-enteritis," or "intoxication," or "summer complaint," as it once did with such painful frequency. It is my constant admonition to keep the infant wards as empty as possible and I always feel that the degree of emptiness of these wards is a proper measure of the efficiency of the out-patient department, and, of course, of all the other modern infant welfare agencies as well.

I have said that there must be an adequate

physical equipment. I did not say an ornate physical equipment. I am always frankly skeptical of an institution that is too beautiful, too elaborate, too perfect. Some of the best pediatric work that has ever been done has been done in basements with meager equipment. I could cite many instances of this and some in which productive efficiency was lost when the equipment became lavish. Many of you will call to mind at once a very old children's hospital that is anything but esthetic, or modern in appearance, from which there has come for years a steady stream of the most substantial and lasting pediatric work.

I saw recently a new modern children's hospital—the million dollar plus kind that represents the last word in equipment and in esthetic perfection. There was an exquisite chapel; marvelous rural paintings and carved woodwork; a marble fountain with goldfish in the basin. I saw some children behind glass partitions. One could hardly ask to see the linen closets in such a setting. I am frankly interested in seeing what will come of it.

There is, on the other hand, one esthetic accessory that promotes enjoyment and efficiency—a soft, warm, restful, neutral color scheme in mural decoration and in equipment. We were peculiarly fortunate in this respect in having the services of a woman who has a perfect color sense and we are profiting by it.

An out-patient department should be large enough, and should be so arranged, that patients can quickly be sent to a number of smaller waiting rooms, and there should be one or more isolated rooms to which possible carriers of contagion can be sent as soon as they are suspected, preferably at the point of entrance to the clinic. Each clinician must have one, preferably two, quiet rooms. The only needed equipment is a table, a couple of chairs, a washstand, soap, towels, sheets and some wooden tongue depressors. The clinician will have his own stethoscope and otoscope. The special clinics will, of course, require their own special equipment.

Laboratory Should Be Accessible

There should be a small laboratory, or laboratories, easily accessible for simple laboratory tests, and a larger, fully equipped laboratory for immediate complete blood, urine and smear examinations. The x-ray department should be close at hand to permit of fluoroscopic examinations and the taking of pictures, so that it will not be necessary to take the patient into the hospital for even a day, except in the special case. There should be one or more quartz lamps for ultraviolet ray treatment of ambulatory cases of rick-

ets, spasmophilia, certain forms of tuberculosis and some other conditions.

It is desirable to have, as far as possible, all clinics on one floor, and at one time, to facilitate easy interconsultation with other clinicians, medical and special.

The working organization of an out-patient department must necessarily vary with its size and nature. The simpler it is, the better. Even in the largest out-patient department neither the patient nor the clinician should feel lost, or bewildered, in a maze of organizational red tape. A large, but simply and smoothly organized clinic can be considered under the following heads: the patient; the doctor; the nurses and social service workers; paid and volunteer workers; the student; the record.

Patient Should Always See Same Doctor

Let us consider first the patient. Having passed the first scrutiny and answered a few questions regarding temperature and perhaps weight, the old patient is sent at once to a smaller waiting room adjoining his ultimate destination. As far as possible he should see each time the same clinician both for his own sake and that of the clinician. The effect upon the patient of seeing each time a new or uncertain doctor and vice versa, is obvious. No one would accept such an arrangement in a private practice—the constant ideal to be aimed at. The clinician who does not follow his cases for months, even years, loses one of the most valuable advantages that the out-patient department can give him, as compared with the wards where he sees them for only a short time for one illness. If so treated the out-patient department child becomes a patient—not a case, as in the wards—a part of a clientele as in private practice. There is a great satisfaction in a friendly, voluntary, medical ownership—owning and being owned.

In addition to these things the new patient must be questioned, I think we are all agreed, as to his financial status, and except in an evidently flagrant case, the mother's word must be accepted as true. For this purpose there should be a separate, isolated, room that insures absolute privacy. Poor patients are often more sensitive than are those who are more affluent or less deserving. The investigator must be a person of infinite tact and patience; one especially trained for that purpose; one having both a heart and a head and both functioning equably. The patient's whole attitude toward the clinic can here be influenced for good, or bad, and first impressions are deep and lasting. The deserving patient must not be questioned to the point of embarrassment; and in the question-

able case it is sometimes, or shall I say often, well to remember that "the quality of mercy is not strained;" that it is often not only better, but safer, to err on the side of rendering an efficient medical service, than to throw an innocent patient back upon the mercy of what may be known to be an inefficient service.

Who Are Eligible as Patients?

There must, of course, be some fixed scale, but not too fixed, as to income and number of children and other dependents. But such factors as debts; temporary unemployment; great and urgent special medical need; whether the child merely needs an examination with one or two calls as compared with an operation and long after care in a hospital, must enter into the decision. After all we are not coldly selling merchandise with a fixed price to all; we are dealing with human values, with children who have not even a choice as to what is to be done with them. A routine, mechanical, institutional heart must never replace the real one, and especially not at just this point.

In every well organized out-patient department of any size there must be a chief of clinic, who looks after the details of the organization and the management of the clinic. If he is qualified to do so, and is able to give the necessary time, he can also act as consultant. In a larger clinic it is of the greatest importance to have, in addition, an older seasoned clinician who has the confidence of the younger men, who either spends a short time of each day in the out-patient department; or who spends there one or two fixed periods each week, so that patients can be brought back to him for consultation; or who is at least available and accessible for consultation by being in the hospital during the dispensary period. There is nothing so stimulating to a younger man as a satisfactory consultation, on a perfectly frank basis. If he is put right he has learned by the most useful method; if he was right, or if the consultant cannot help him, he feels encouraged or relieved and learns the useful lesson that medicine is still an art as much as a science. If this arrangement is, unfortunately, not feasible, it is then often a good scheme to have each day one of the more experienced men of the out-patient department act as consultant for the day.

One of the most difficult problems is to obtain regular and prompt attendance on the part of the clinicians. I know of no remedy except the building up of a tradition, and the setting of a good example.

I think in general that the minimum attendance in the medical department should be three periods a week of two hours each. With some clini-

cians daily attendance is desirable; in exceptional cases only one or two periods a week can be granted, but this is a distinct loss both to the clinician and to the patient. The man who comes three or more times a week has a vocation—if only two times or less, an avocation—and there is an important psychological difference.

In all clinics there is, of course, a division of work into medical, surgical, orthopedic, otolaryngologic, etc. In smaller clinics the medical man, the pediatric internist, naturally looks after all medical cases. In all larger clinics, with abundant material and an abundance of well qualified clinicians, there must be a degree of specialization in proportion to these two factors. We have found it indispensable to the patient, to the clinician, and to the practical and productive efficiency of the clinic, to have the following special medical clinics: dermatologic; cardiac; syphilitic; neurologic and psychiatric; renal and pyuric; diabetic; speech defect; ultraviolet ray; and, for greater facility in handling such patients, a separate baby clinic, which is thrown open to all clinicians.

Clinics for Special Studies Needed

From time to time, still more specialized clinics have been established for special study, such as asthma, eczema, goiter, epilepsy. For such purposes all patients of this type are referred to one man, or a group of men for intensive study. The advantages of specialization are obvious; the patients get a more intelligent, intensive, and personal attention; the clinician becomes an authority, and has the opportunity for intensive study and investigation. The disadvantages are perhaps more apparent than real. The nonspecializing clinician is naturally denied the study and the observation of the special cases. This can be alleviated to a considerable extent by having him assigned, if he so wishes, in turn with the others, to part-time attendance on the special clinics in which he can see a large amount of such material in a short time under intensive and instructive conditions. The fact remains, further, that the largest, the most interesting and varied, the diagnostically most difficult material, remains to him, and this the specialist is denied. It is this remaining clinical material that I use for all my clinics, from choice. The man who conducts a special clinic should, *ipso facto*, be ready and eager at all times to teach the others, and is expected to carry on some constructive as well as practical work.

The advantages of the special clinic from all of these viewpoints is evident from a concrete example. Some five years ago all of our kidney cases were referred to one man who has followed them since that time. Before that time these cases

were treated in a more or less haphazard way in the general medical clinic. After a variable time the patient was lost and we had no idea as to the actual fate of such cases. In these five years more than 150 cases have been studied and followed, with most interesting results; and investigations have been carried on with which all those interested in this subject are familiar. The syphilitic clinic, in which patients are so easily lost before adequate treatment has been carried out, with the inevitably tragic result, has grown by leaps and bounds, both in efficiency, and in attendance and cooperation. Nowhere is the importance of having the patient always see the same doctor each time so evident as in the special clinic, where this is a necessary part of its conduct. To rotate special clinics among the attending men every three or four months would seem to me wholly undesirable—all the advantages to the patient and clinician would thus be lost, all the disadvantages retained.

With few exceptions all of our men serve some time in the out-patient department. On the other hand, we attempt as much as possible to give each out-patient department clinician some house service as soon as possible. The special clinicians serve both in the out-patient department and in the house, in their special field. We encourage every man to lay off for at least two months each year, to avoid staleness.

Many Workers Are Needed

The necessity of having an ample supply of nurses and social service workers is evident. In our clinic of some 35,000 visits a year we have three graduate and three undergraduate nurses, and six social service workers, plus a Ford. We have found it of advantage to have one person who is at the head of all of these activities, as they are intimately dovetailed. There is no more important single person in a dispensary than this individual, who should be not only a nurse but one especially trained in this type of work, and a person of broad experience and broad sympathies. She has no easy task and easily becomes a storm center if she is lacking in tact, is dictatorial, or temperamental, or is too much imbued with the idea of the relative sphere and importance of her own work. Clinicians, too, are perhaps at times a little temperamental, and nowhere is a reasonable cooperation more important than here.

Not all of the attendants need be trained nurses by any means, as, for example, the admitting clerk, the financial investigator, a stenographer, the psychiatric workers and the psychologists.

There is a class of clinical attendant that has served us with peculiar efficiency and usefulness.

I refer to volunteer workers. One of the things that has made, and always will make, dispensary work irksome, unless it can be alleviated, is the necessity for keeping adequate written records. Competent stenographers and dictaphones would solve the problem but are too expensive. This work is largely done in our clinic by a well organized, highly intelligent, sympathetic and faithful group of some thirty women who are interested in the hospital. The clinician dictates as he proceeds. He learns to dictate, no mean accomplishment and he does not need to take the time to write, no small advantage. These workers also help in weighing babies and taking temperatures.

Women's Board Is Helpful

Another side that never fails to appeal to me is worth emphasizing. We know that we have a wonderful board of trustees, and perhaps an even more wonderful women's board. But they are infrequently in evidence. To have daily a half dozen, or more, women of this type with a true spirit of service, faithful in attendance and faithful in their work, an integral part of the clinic, promotes a stimulation and an uplift that is felt throughout the whole clinic. I do not know to what extent this is done elsewhere but we can enthusiastically commend it for trial. There is behind such an organization and such efficiency a tradition that it takes time to develop. A proper leader can do it.

If there are undergraduate students in the dispensary there is less need for volunteer workers. The student writes the histories, examines the patients, makes the necessary special tests and reports to the instructor. Undergraduates are a desirable part of a dispensary. They teach each clinician to be a teacher—and every clinician should be at all times and everywhere a teacher. The short-time postgraduate can hardly be admitted to the out-patient department unless "personally conducted." The long-time postgraduate will find in a well conducted out-patient department, first under supervision and later as attending man, the most valuable practical clinical experience he will ever get. It is perhaps not necessary to say that patients, or rather their mothers, do not object to clinics—that, in fact, they like them. They soon learn that more thorough work is done where clinics are held and they realize that they get the benefit of consultation. Then, too, it is a normal human reaction rather to enjoy having something important enough to be referred to the "professor" or to the big clinic.

The intern is still a student and all that has been said applies to him as well. The greater dif-

ficulty in diagnosis and treatment, and in that most important pedagogic factor, tact, and contact with the mother in the out-patient department as compared with the wards, is recognized by us in that we do not allow an intern to work independently in the out-patient department until near the end of his internship. That we have succeeded in making the out-patient department instructive and interesting is evident from the fact that, practically without exception, every intern looks forward to his service in the dispensary, where he is put on his own as attending man, as far and away the most important and responsible service of the whole year. I record that fact with a great deal of satisfaction.

Lastly, let us consider the record. The out-patient department lends itself peculiarly to investigation of a statistical nature, and this is always valuable and to be encouraged. It is necessary not only to have adequate records, it is also necessary that they be filed not only by name and number but also by disease. This represents an enormous amount of work and means an extra filing clerk, or two. It is, therefore, commonly omitted. Such omission makes the records all but worthless for the purpose indicated and should not occur in a well conducted clinic. The records and progress notes of an out-patient department are necessarily not as complete as those of the wards. To have them so would represent a needless amount of wasted energy. The important case must, however, be recorded in full with adequate progress notes, and, with such help as I have indicated, they can be. There is much to be said in favor of the unit system of record keeping—much to be said against it. I have no solution to offer. The out-patient department record in the dual system of records must, however, accompany the patient who enters the hospital and must be returned to the out-patient department with an adequate written report of what occurred in the hospital.

O. P. D. Work Need Not Be Drudgery

I come now to the last and greatest factor—the spirit and not the matter. No abundance of patients; no abundance of good clinicians, nurses, social service workers, paid and volunteer workers and students; no amount of physical equipment, will make an optimum out-patient department unless there is back of it a spirit of enthusiasm and of helpful cooperation. There are still many who marvel that anyone, especially an older clinician, can speak with enthusiasm of dispensary work. There are encouraging signs on all sides that that attitude is changing. How can the change be hastened and made more complete? In several ways. The younger man must not only be told,

he must not only be shown, he must see that there is no more valuable and interesting work anywhere in medicine. Nothing contributes more to this than a knowledge that he can at all times have free and immediate access to eager and sympathetic consultation with older men who have had a wider experience and can see more from that point of vantage. He thus remains a student and not a drudge.

I know of no better way to illustrate the value of the older, seasoned, clinician in the out-patient department than to repeat an incident that I have related elsewhere. A clinician in a dispensary near Düsseldorf once said ingenuously to a visiting pediatrician of my acquaintance: "You know, it is a funny thing, but we go on here for days with just the ordinary things; but every time Schlossmann comes to visit us we have the most interesting lot of things in the clinic."

Enthusiasm Is Contagious

Equally important is a free interconsultation and demonstration of all interesting cases to one another. Every clinician should be both student and teacher and should see or show every unusual case, and in a large clinic no day passes that there are not several. There is, too, something contagious about enthusiasm, especially if it has outlived youth, and close and sympathetic association with young and eager men is of value to the older clinician.

Lastly, the out-patient department attending man should be on a basis of equality with the attending man in the hospital. There should be no line of cleavage. With us every man who works in the hospital has a seat and a voice and a vote in the staff meetings; and a rank that recognizes no geographical barriers.

I am convinced that an autocracy of organization brings the best results. This must be combined however with an absolute democracy in its conduct. The infallibility of the professor has no longer a place in medicine. The youngest intern (and how well informed they do come to us!) is entitled to his opinion, and is entitled to express it, as freely as is the chief of staff or anyone else. If he is shown his error, he has learned in the most effective manner; if he is right, we have learned even more unforgetably. I have never shared the idea that a nurse, like a good child, "must be seen and not heard." Her opinion may be as valuable as my own, and I never hesitate to ask her to express it. Medicine is a large field with many angles; there is room for all of us; only the weak head hypertrophies and dilates; and it is well to remember that in medicine "*errare humanum est.*"

Newark Beth Israel Hospital Has Unique Features

By FRANK GRAD

Architect, Newark, N. J., and

S. S. GOLDWATER, M.D.

Consultant, New York

RARELY does it fall to the lot of hospital planners to design with a free hand, even within the limits of a fixed appropriation. Such an opportunity was given to us in connection with the new Beth Israel Hospital, Newark, N. J.; the result is a hospital scheme which, so far as we know, has no counterpart in this or any other country. That this novel form has both theoretical and practical advantages we shall endeavor to show.

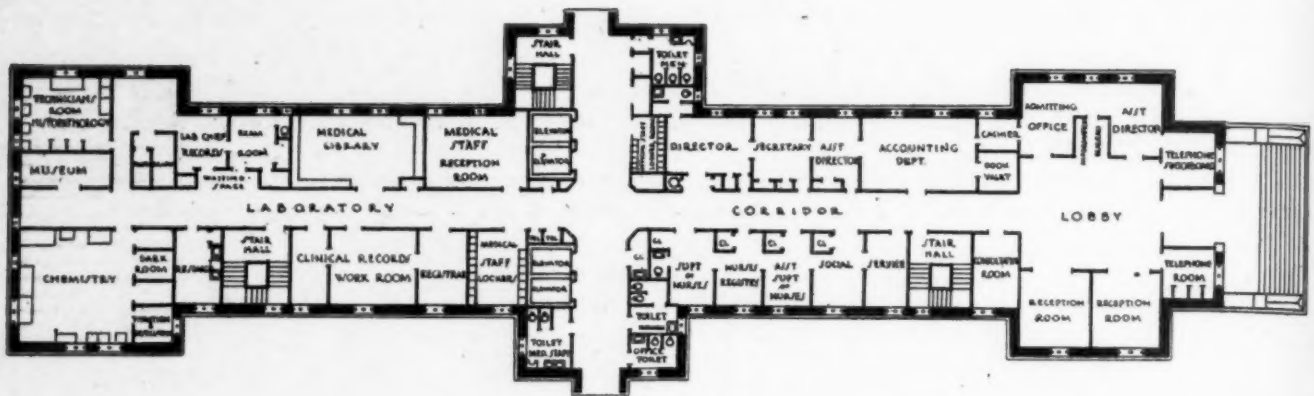
The land that was purchased by Beth Israel Hospital for its new construction originally con-

sisted of two parcels, divided by a narrow street. As this street was not important to the neighbors, permission was sought from the city authorities to close it; this done, there was available a plot measuring 430x460 feet, with street frontages on three sides.

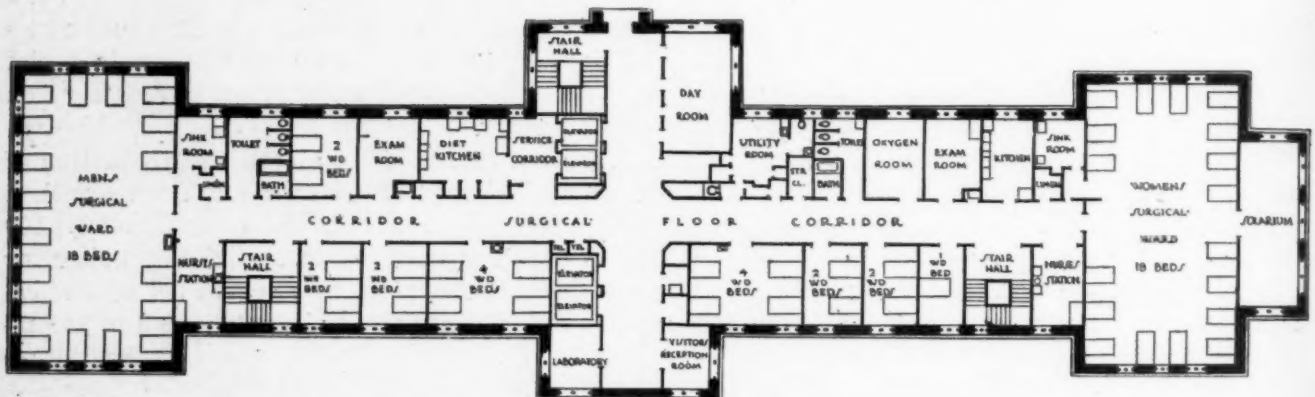
We were instructed to aim at the production of a hospital of not less than 250 and not more than 300 beds. There were to be approximately 100 ward beds for women and a similar number for men. The wards were to be classified as medical and surgical, but were to be subdivided to accom-



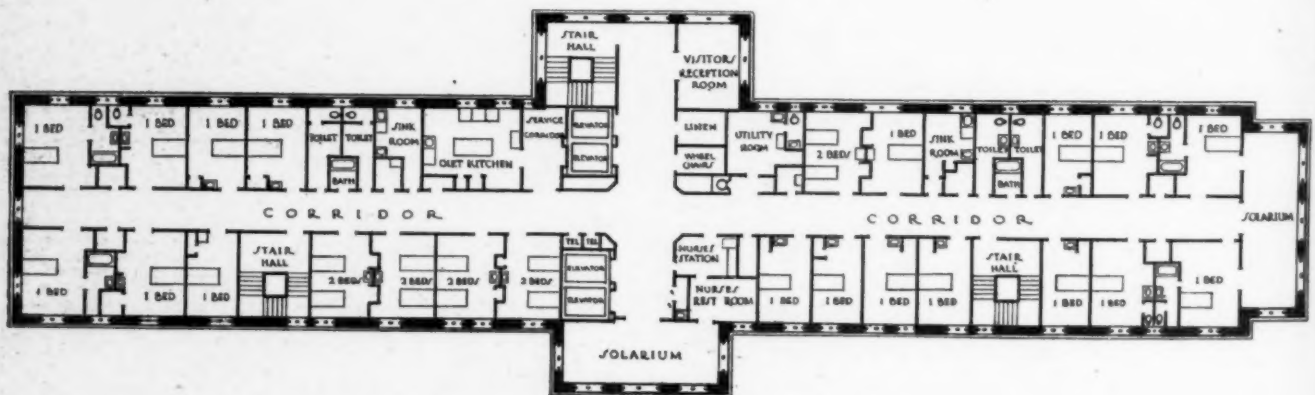
Patients' building and medical service building, Beth Israel Hospital, Newark, N. J.



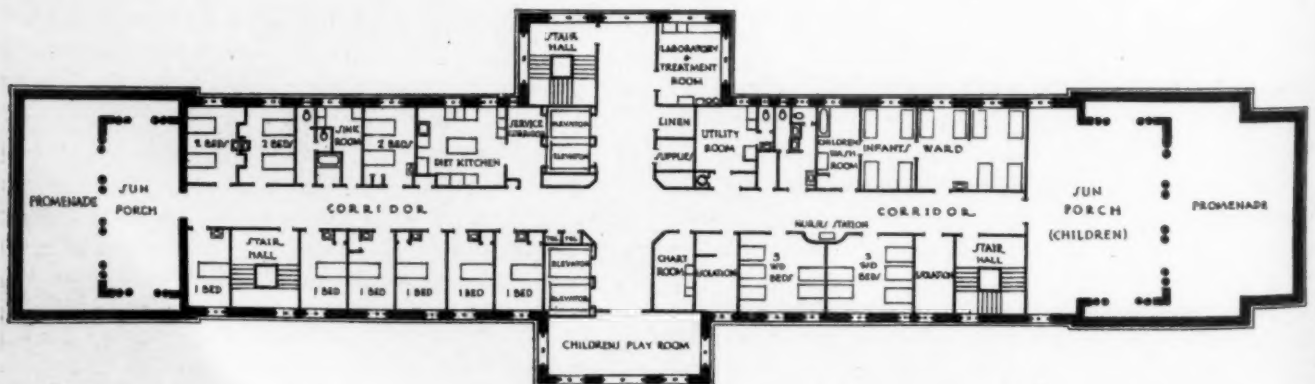
First floor, main building.



Ward plan, main building.



Fourth, fifth and sixth floors, main building.



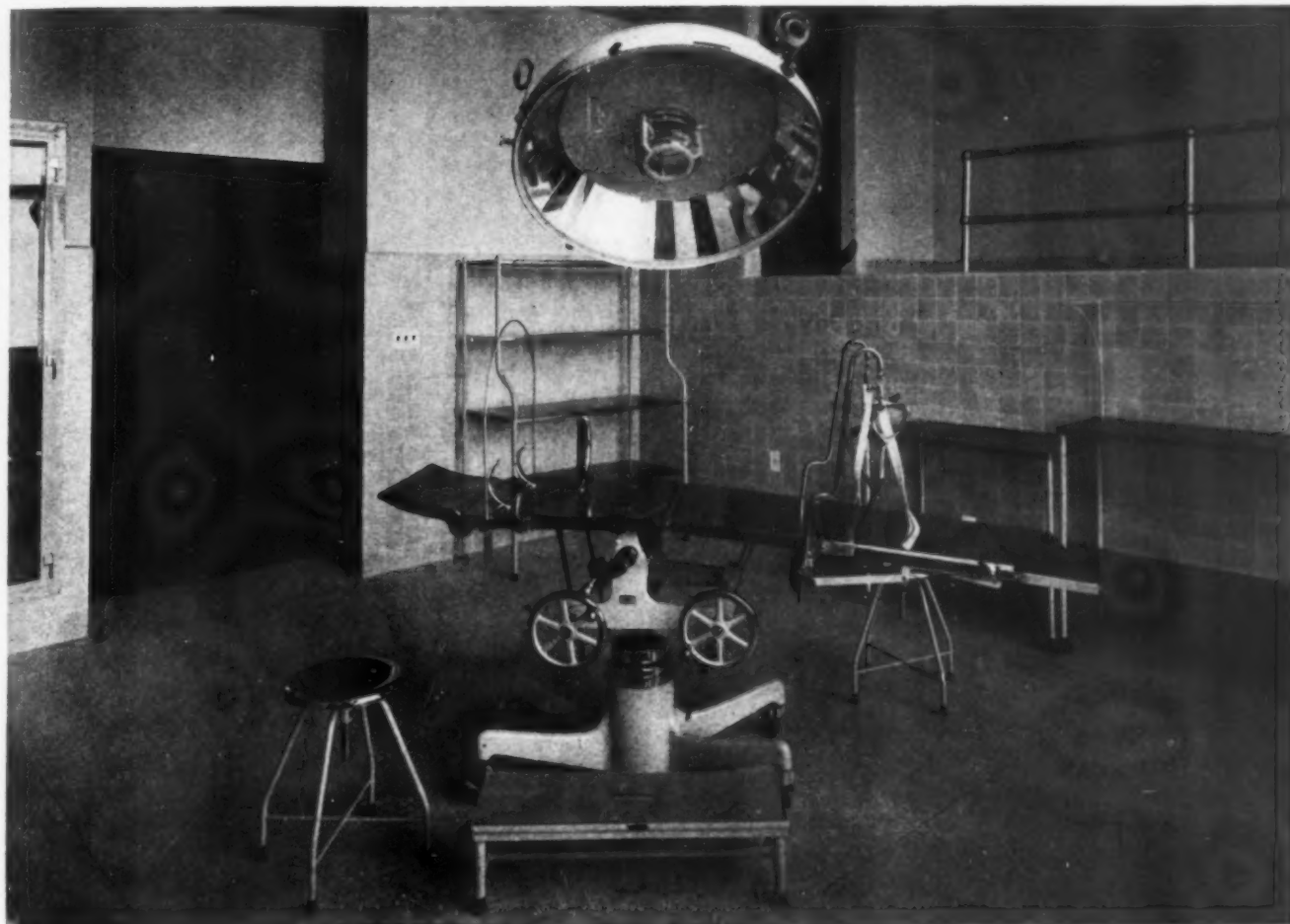
Seventh floor, main building, devoted to children's accommodations.

modate certain specialties. Private and semiprivate rooms were to be arranged so that single rooms could on demand be converted into double rooms, and vice versa. There was to be a maternity service for private, semiprivate, and ward patients. For the children's department, there were demanded accommodations for medical and surgical cases, a special ward for infants, and rooms for private and semiprivate patients. Opportunities for expansion were not to be overlooked.

Noise from both external and internal sources

ing, with its arms extending east and west, and with its stem (the stem of a reversed T) running toward the north. It is our thought that this future building shall be chiefly for the accommodation of the maternity service, but if the maternity service is placed on the upper floors of this building and thus isolated, there is no reason why the lower floors cannot be used for other clinical classifications.

The main line of communication within the clinical building runs vertically through the central expanded portion. Visitors approach from



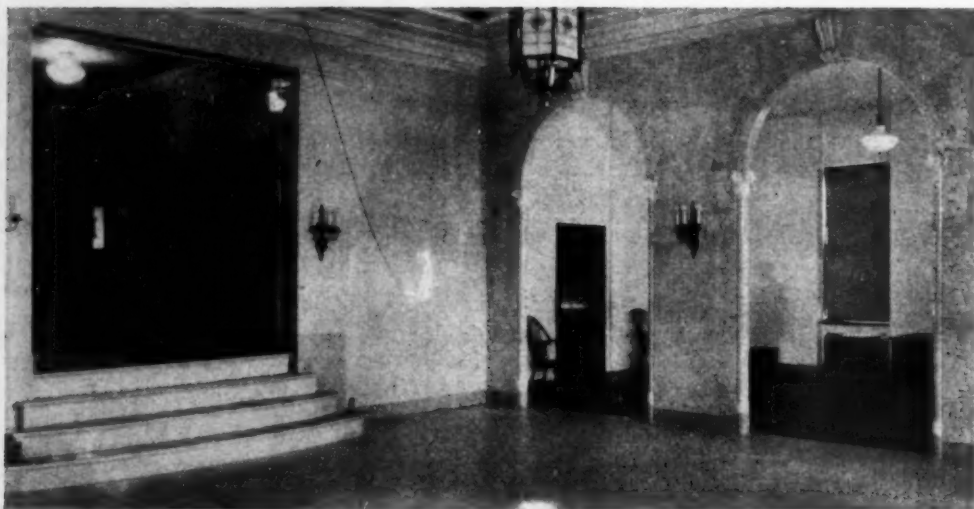
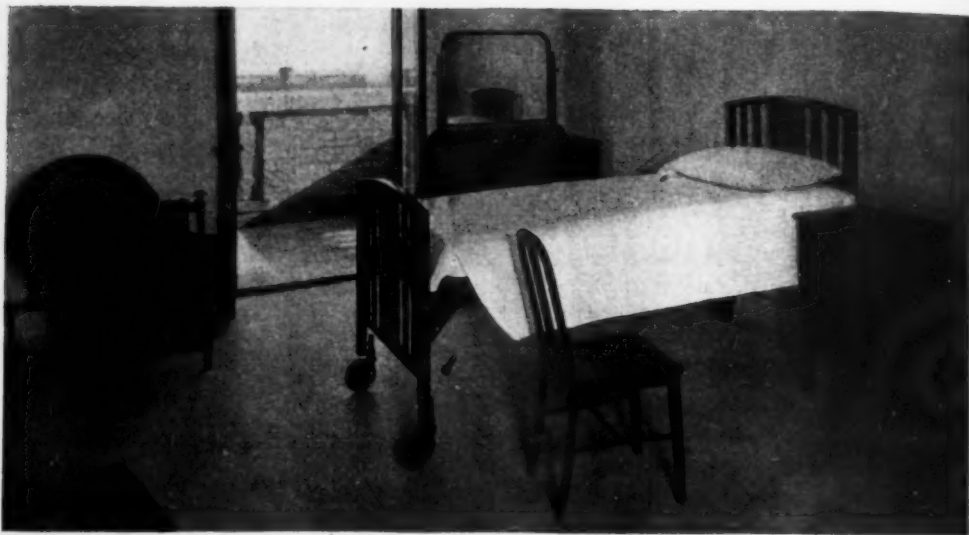
Operating room, with spectators' gallery.

is the *bête noire* of modern hospitals. We wished to get away from street noises, if possible, and adopted the idea of placing the main building as far away as possible from the street. A modified I-shaped building having been determined upon, we found it advantageous to throw this building diagonally across the lot, in order to obtain some sun exposure for all rooms. The axis of the main building is approximately north and south. With the principal building thus placed, it will be easy in the future to add a second clinical building at the northerly corner of the plot. This future clinical building is intended to be a T-shaped build-

the south end, and having passed through the office section on the first floor, find themselves in the central elevator lobby.

Extending east and west, respectively, from the central tower, are the domestic service building and the medical service building. It will be noticed that these buildings are low and do not therefore shut out light and air from patients' rooms. The roofs of the service building presented an opportunity for outdoor comfort for the patients. On each roof there has been erected a solarium and a covered loggia, but a considerable section of each of the roofs is exposed to sun and

On the right is seen one of the private rooms, opening off which is roof space where the convalescent patient may get sun and air.



Here is the spacious entrance lobby. The walls are of Tavernelle marble and the well proportioned arches are noteworthy.

There are two solariums on each ward floor. On each roof there have been erected a solarium and a covered loggia, as shown here.



sky. One of these roofs will be assigned to private patients, the other to ward patients.

As the principal building climbs upward, the floors recede. The lower floors, used for administrative purposes and for wards, are slightly expanded at the extremities of the main stem. These extensions grow out of the requirements of the respective departments. There was no need for such expanded areas on the upper or private floors, and at the first setback, small roof areas are available in connection with certain private rooms.

Children Are Apart from Adults

For the children separate sun porches and roof promenades were desired, since sound hospital procedure requires that children be kept entirely apart from adult patients as a sanitary safeguard and for the comfort of the adults. Fortunately, the program called for a smaller number of children's beds than could be accommodated on a full floor, and by locating the children's service on the seventh floor (the whole general service is below this level) it was possible to create a setback at either end, and thus to obtain separate loggias and exposed promenades for ward and private room children.

For the maternity service complete separation was desired; there should be no unnecessary traffic through this department. Isolation was obtained by placing this department in the upper stories of the building. The ward and semiprivate maternity services are on the eighth floor. The ninth floor is for the use of private maternity patients. On the tenth or first central tower floor are the delivery rooms, with separate suites for ward and private patients. The eleventh story of the tower is a convalescent solarium; adjoining this is a roof promenade. There are additional solariums on the second, third, fourth, fifth and sixth floors.

The diagonal placing of the main building and the arrangement of the clinical departments within it constitute but one of the distinctive features of the plan. There is another characteristic feature to which attention is invited.

Relations of Service Departments

In the modern hospital, patients require (apart from their actual bed care) two principal types of service, namely, diagnostic and therapeutic (or medical) service, and kitchen and laundry (or domestic) service. The medical service embraces laboratories, operating rooms, radiology, cardiology, physiotherapy, metabolism and the like; the domestic service includes kitchen, laundry, and supply rooms. The diagnostic and therapeutic

division of a general hospital must be prepared to receive both in-patients and out-patients, and the logical position for these departments is, therefore, midway between the ward and out-patient departments. The domestic division must provide for two main groups of hospital inmates, that is, patients and nurses, and the logical position for the domestic service building, therefore, is between the patients' building and the nurses' home.

In the present plan the two service buildings extend from and are directly connected with the central or vertical distributing tower of the main building, and the logic of the scheme is revealed by tracing the handling of food supplies, for example, from the point of their reception through the kitchen department to the central elevator stack, or by tracing the route of newly admitted patients from the ambulance entrance through the receiving ward to the elevator tower—the central distributing point for each patients' floor.

Design Is Shape of Greek Cross

Many hospital buildings have been erected in the last few years in the shape of a Greek cross with four extensions of equal height, but none of these resembles the Beth Israel Hospital. In the present case the two lateral arms of the cross are low buildings, freely designed according to the needs of the contained departments. In the more conventional plan the special service departments are often made to conform to a floor plan designed primarily for private rooms, and operating and other rooms of improper size are the result.

By keeping the service buildings low and reserving them exclusively for their special uses, it was found that more satisfactory planning could be done, and by housing all of the patients in the taller central stem, perfect sun exposure was obtained for all patients' rooms, a desideratum which unfortunately is sacrificed when all of the wings of an X-shaped building are carried to an equal height. A study of the plot plan will show how readily future extensions can be made to the service buildings, as well as to the out-patient building and the nurses' residence. The conventional X-shaped building is inflexible; our plan is not.

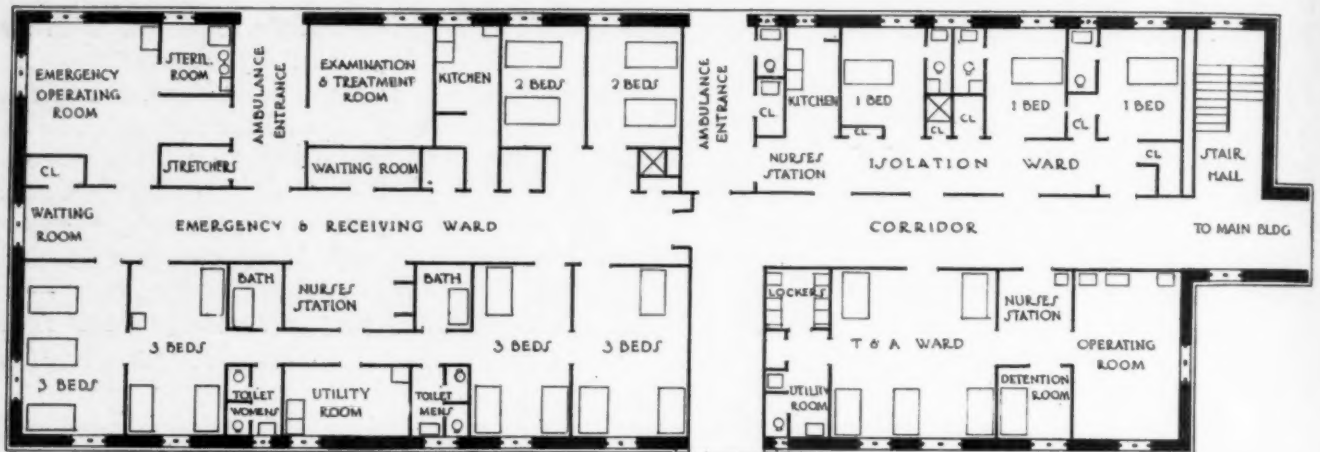
To describe intimate details of the planning and equipment would require far more space than is here available. Only a few points will, therefore, be touched upon.

When ward patients and private patients are accommodated on different floors of a single hospital building of considerable capacity, it is desirable to provide a separate entrance and waiting room for ward visitors to be used during ward

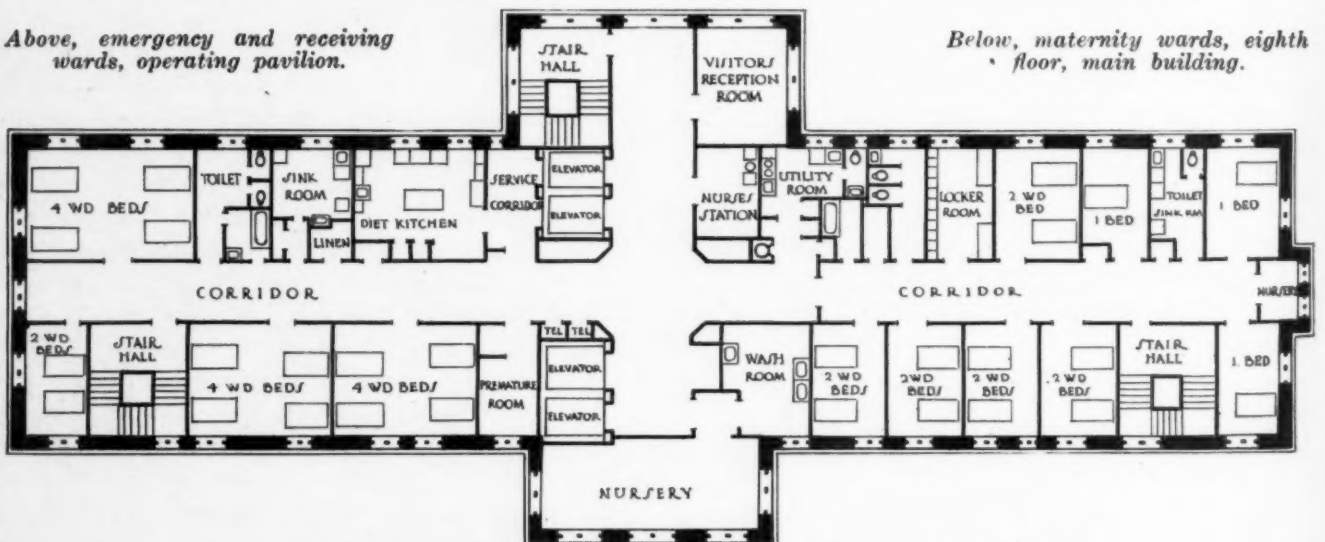
visiting hours. The ward visitors' waiting room at Beth Israel Hospital is on the ground floor, beneath the general lobby. Visitors to private rooms pass from the main lobby on the first floor through an office section to the central elevator tower. For the staff room and library the first floor section just beyond the elevators has been appropriated. The north ends of the first floor and basement contain the laboratories.

The ward floors are double units—two nurses'

stations to a floor. To the medical service and its auxiliaries the second floor has been allotted; this floor has a normal capacity of fifty-six beds. On each ward division there are twenty-eight beds, eighteen of which are in an open ward, while ten occupy 4-bed, 2-bed, and 1-bed rooms. Each nurses' station is central to its related territory and directly overlooks an eighteen-bed ward. For each ward unit there is a sink room, centrally located. There are two solariums on each ward

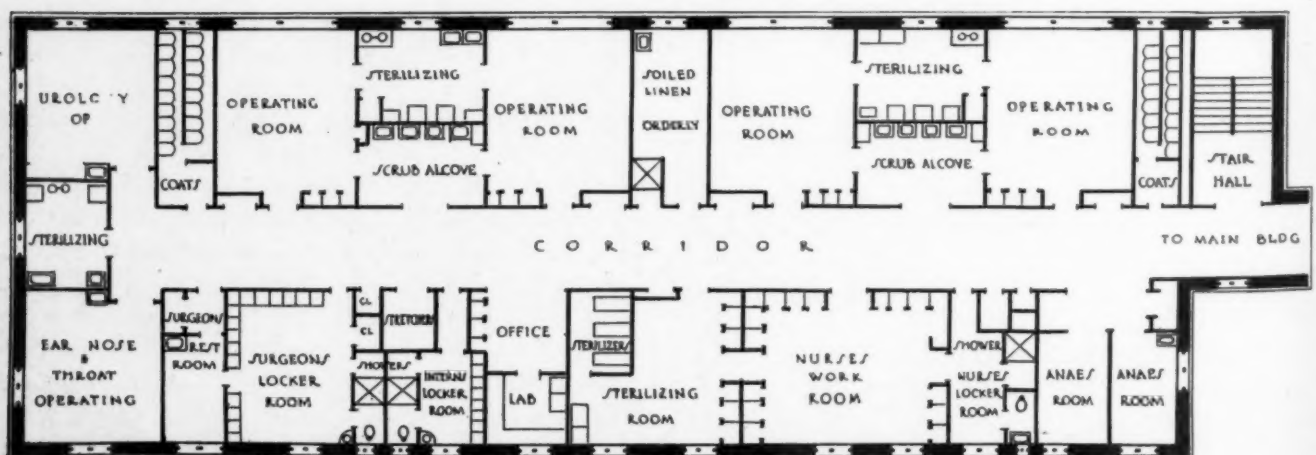


Above, emergency and receiving wards, operating pavilion.



Below, maternity wards, eighth floor, main building.

Below, operating rooms, second floor, operating pavilion.





View of eighteen-bed ward.

floor. Each ward has its own examining room and kitchen. All of the elevators open on side corridors (noise control). There is outside light and there is natural ventilation for each section of corridor. The larger wards have windows on three sides. There is running water in all of the larger wards, the four-bed wards included. Besides the sink rooms, centrally placed with respect to the separate ward units, there is a fully equipped utility room common to two wards.

On the private floors, there is a single nurses' station centrally located, with a control window directly opposite the passenger elevators. A nurses' rest room adjoins the nurses' station. The central utility room of the ward floors is here repeated; in addition, there are sub-sink rooms to each corridor end.

Entrance to Patients' Floors

The visitors' approach to the patients' floors is pleasant and reassuring. Opening off the elevator lobby are a solarium at one side, a visitors' reception room at the other, and as the hospital occupies high ground in a residential neighborhood, the adjacent sections of the city are completely overlooked from the third and all of the succeeding hospital floors.

For eight rooms on each of the private and semiprivate floors (namely, the fourth, fifth and sixth) private toilets or private baths and toilets have been provided. Two sink rooms serve the remaining rooms, and are so placed as to be within close range of the rooms served. Those who are

interested in hospital housekeeping will appreciate the ample linen and wheel chair closets.

The distinctive features of the seventh or children's floor have already been referred to. The separation of the sections intended for private and ward patients, respectively, will here be noted, as well as the separate outdoor facilities for the two groups. The large children's playroom is a delightful feature. The location and general arrangement of the maternity floors have already been stated.

The relation of the medical service building to the ward and out-patient buildings, respectively, has been referred to. The ambulance entrance, emergency rooms, and receiving ward occupy approximately half of the ground floor of the medical service building. The receiving ward is so arranged and subdivided that fluctuating numbers of men, women and children can be cared for. There is a self-contained tonsil and adenoids ward, with an operating room, on this floor. Any possible overflow from the tonsil and adenoids ward can readily be cared for in one of the sections of the adjoining receiving ward. An isolation ward containing three separate rooms with individual toilets, nurses' station, kitchenette and independent entrance and exit, occupies the remainder of this floor. This suite is intended for the emergency care of contagious cases.

The plan calls for a covered corridor to connect the out-patient department with both the ground and first floor of the medical service building.

At the extremity of the first floor of the medical

service building the department of radiology has been allowed the use of about 3,500 square feet. A modest department of physiotherapy, a plaster room, a metabolism room and a cardiographic suite share a central waiting space.

The entire second floor of the medical service building is devoted to surgery. There are four major and two minor operating rooms. For each pair of operating rooms there is a sterilizing room and a scrub alcove. Two of the operating rooms have built-in galleries with side entrances. The liberality of the auxiliary service features will be noted. There is to be an enclosed corridor between the medical service building and the out-patient building.

Kitchen Conforms to Dietary Laws

The kitchen has been planned to conform to special dietary laws. The help's dining room, arranged for cafeteria service, shares the basement of the domestic service building with the main kitchen. Dining rooms for pupil and graduate nurses, medical staff and office staff, are ranged about a central serving room on the first floor, directly above the kitchen. This floor is tied to the nurses' home by means of a covered corridor. The dining room corridor begins at the elevator lobby on the second floor of the tower of the main building. The third floor of the domestic service building contains interns' quarters, as well as a number of suites for administrative officers.

In the nurses' home the classrooms are located at one end of the extremely light basement. The first floor contains living room, library and reception rooms at one end, and special suites with connecting baths for officers and supervisors at the other. On the upper floors the characteristic student's room is a single room, with a large built-in closet and running water. There is, however, one pair of rooms with a connecting private bath on each floor, as well as four double rooms.

In the out-patient building, which is a three-story building designed for future expansion, a section of the ground floor has been utilized for employees' quarters. The out-patient building is designed for a fully classified clinic service. Special features are a central record room, detention room, pharmacy, social service offices, spacious central waiting halls well lighted and ventilated, and an exceptionally large dental clinic, the product of a special donation.

Architecturally, this group with its exterior of buff color brick and limestone, wrought iron grilles and red tile roof of tower and patios, shows Spanish influence. Its commanding site makes it a landmark in the section, while from the upper solarium a wonderful vista of the surround-

ing country is obtained. The wall treatment of the main entrance lobby is of Tavernelle marble, with well proportioned arches and decorative spiral columnettes or imposts with ornamental caps and moulded keystones. The floor is terrazzo. The lighting fixtures harmonize with the architectural treatment.

Corridors are finished with terrazzo floors and flush top sanitary base. Doors are of birch, flush veneered and with walnut finish, with metal frames and flush finished metal trim. Rubber-stone composition floors have been used in all solariums, waiting rooms, and administrative quarters. Terrazzo floors have been used in all private rooms. In the large ward the floors are of terrazzo, with field of rubberstone. Diet kitchens and utility rooms have tiled walls and terrazzo floors. The children's department on the seventh floor is glazed with glass that does not keep out the ultraviolet rays of the sun.

The general decorative treatment of plastered surfaces is a light buff color for the walls, with ceiling surfaces tinted off the white. The built-in metal equipment is finished in gray instead of the more or less usual white finish. The color of the finish of all metal trim (except on the children's floor) is brown, while the children's floor is entirely in gray.

Gray Walls Used in Operating Rooms

The six operating rooms are finished with pale gray tiled walls and terrazzo floors. Tapestry glass screens are provided across the window openings in each operating room. Sterilizing rooms have tiled walls and terrazzo floors. The foyer in the nurses' home is treated with Caen stone walls, while the reception room is inviting, with its fireplace, decorated and paneled walls and oak floors.

The main building and nurses' home are steel skeleton construction, with removable metal tile or ribbed slab floor system. The smaller buildings are wall bearing for exterior walls, and steel skeleton for interior framing; the floor system is the same as above. All skeleton walls are face brick with back-up tile, but in certain instances solid brick walls are used. Basement walls and generally walls to grade are either plain or reinforced concrete.

The basement and subbasement wall of the boiler room and power house, and the foundations for same, are of heavy reinforced concrete construction, on account of the comparatively great depth below grade. A network of tunnels for heating ducts, etc., is used under the basement floors. Footings and wall foundations are soil bearing of the usual spread footing type.

The tower of the main building houses the elevator machinery and water tanks. The extreme sloped tower roofs are constructed of precast portite slabs set between T-irons. Due to its height and other structural considerations, a nominal amount of wind bracing was provided for the main building.

In general all plastered ceilings are "clipped" ceilings, namely, plaster on metal lath, except where furred or hung ceilings are used. Except where special finish is used, such as tile or terrazzo, the floors are cement finish on cinder concrete filling.

Mechanical Features

Steam is generated in two 250 horse power high pressure boilers, equipped with feed water heater and steam driven boiler feed pumps, with provision for two additional boilers. These boilers are fired by means of oil burners, with a 22,000 gallon oil storage tank located outside the building, underground, capable of storing about a two weeks' supply of oil.

High pressure steam is reduced to three lower pressures, first for laundry and sterilizer use, second for kitchen use, and third for heating purposes. All rooms throughout the building are heated by means of a two-pipe vacuum steam system to 70° F., except in operating and maternity sections where a 75° temperature is used.

In the main hospital building and operating pavilion all toilet rooms, utility rooms, serving kitchens, and all wards and private rooms containing two beds or more, have exhaust mechanical ventilation, with a varying air change of from three to twelve changes per hour. In the nurses' home and in the out-patient department all toilet rooms and all places where patients congregate have mechanical ventilation and, in addition, all toilet rooms have gravity ventilation, so that ventilation is provided when the mechanical system is not in operation. The ventilating system of the kitchen is separate from the others.

The drainage piping is of genuine wrought iron, and all hot water lines are of brass. Acid-proof lines are used in connection with the laboratory. All sanitary sewage has been kept separate from roof and yard drainage lines.

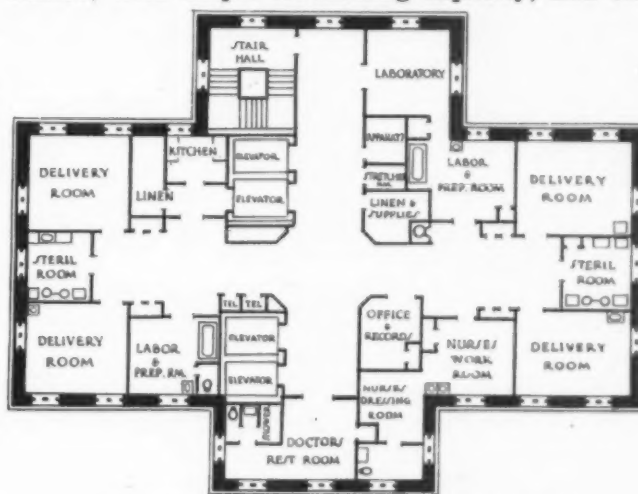
Adequate hot water has been provided by the installation of three large hot water storage tank heaters. Automatic house pumps maintain a uniform supply of water in the house tank. A complete system of standpipe lines has been provided for fire protection.

Compressed air and vacuum lines have been provided in all operating rooms, as well as emergency gas outlets.

High tension current is brought to a transformer vault in the building from two separate power houses. Automatic throw-over switches have been provided in case one source of supply fails, so that the other source will be brought into service. In addition to this, a considerable portion of the building power and light is supplied through duplicate feeders, with manual throw-over switches. Emergency lighting in operating rooms has been provided through a storage battery set, which gives a third source of supply.

Practically all rooms and wards are equipped with telephone outlets, radio outlets, power outlets for the operation of hospital equipment, night lights and nurses' calls. A complete doctors' call system has been installed, and cardiograph lines run up to convenient points in the corridors.

A refrigerating plant in duplicate has been installed, with ample ice-making capacity, and cir-



Delivery room, tenth floor, main building.

culates brine to all kitchen and utility room refrigerators located throughout the buildings.

The kitchen equipment is largely in monel metal. Cooking will be done by gas and steam.

Much of the laboratory equipment is of acid-resistant soapstone, and cabinet construction is of enameled steel.

Up-to-date sterilizing equipment has been provided, as well as an incinerator for burning all rubbish, garbage and other matter. A modern laundry of ample capacity has been installed.

The four main elevators are of the unit multi-voltage type, with machines mounted in a tower construction at the top. All other elevators have machines located in the basement.

Acknowledgments are due to many helpful collaborators, including Abbott, Merkt and Co., consulting engineers; Dr. Paul Keller, superintendent of the hospital; Dr. Max Danzis, the chief spokesman for the medical staff and, more especially, to Frank I. Liveright, president of the board, and a vigorous building committee.

How the Laboratory Functions in a Children's Hospital*

By M. G. PETERMAN, M.D.

Milwaukee Children's Hospital, Milwaukee, Wis.

THE modern pediatric hospital is not complete without a fully equipped, adequately manned laboratory, wherein the modern methods of diagnosis may be carried out under adequate supervision and with proper evaluation.

Scientific medicine demands that an accurate diagnosis be made in the shortest time possible. As many laboratory procedures and aids shall be called into service as are necessary, and these procedures should be made available in the children's hospital to every physician, at a reasonable cost to the patient.

Sick children are brought to the hospital not only for nursing care, for this may be obtained at home from the mother or from the trained nurse; not only for the physician's convenience, because that is secondary; not only for special diets, for these, too, may be provided in the home; but for the greater advantage of laboratory aids in diagnosis, treatment, and prognosis. Here then, the children's hospital especially has an opportunity to offer superior facilities in the care of sick children. Modern pediatric institutions are developing their laboratories to the fullest extent.

Scientific Medicine Needs the Laboratory

The physician who boasts that he establishes diagnoses and carries out treatment in 90 per cent of his cases without the assistance of scientific medicine or laboratory aids, is a general practitioner who accepts the mother's diagnosis of "worms" or "colic," and proceeds to prescribe treatment; who diagnoses "anemia" without classification, (and sometimes with a hemoglobin of 80 per cent and an erythrocyte count of over four million); who considers all kidney lesions, "nephritis," and abdominal pain with vomiting, "appendicitis;" and who allows the diphtheria carrier to prove himself through tests on innocent susceptible persons. True enough, in ordinary general practice "colds," otitis media, feeding cases, burns, pneumonias, heart lesions, and many

other diseases may be diagnosed and treated without blood counts, cultures or x-ray examinations. But when is a tonsillitis diphtheria, or Vincent's angina; when is a chronic otitis media diphtheritic; and when does a pneumonia develop empyema? How early can meningitis be diagnosed without an examination of the spinal fluid and blood, and what about the type? How can the anemias and leukemias be recognized and classified without a study of the blood? I might exemplify indefinitely, only to reach the evident conclusion that the man who does not need the laboratory today is the man who does not understand scientific medicine and its possibilities.

Laboratory Should Be Accessible

The laboratory should be placed in the hospital so that the patients are easily accessible to the technicians, and the laboratory is easily accessible to the interns and staff members. Specimens must be transported in as short a time as possible. Interns should be required to see the results of the examinations. They should also be required to serve part of their terms in the laboratory in order that they may become familiar with all of the routine examinations. However, the average intern cannot supplant a qualified technician. If the intern's results are to be accepted for record or for scientific report then his work must be checked by competent supervision, at least until he becomes proficient. Certainly the average intern's technique in bacteriology, serology, blood chemistry and hematology cannot be accepted in a scientific study.

Staff members must be encouraged to visit the laboratory and personally note the findings in their cases. If they feel true scientific interest in a case they will not be satisfied by reading the laboratory reports alone or by reading a description of the findings at autopsy. The staff members must be encouraged, if necessary, to see unusual blood smears, unusual bacteria, tubercle bacilli, precipitations and the other findings on their cases, and they should attend all autopsies. The interns must be required to assist and take notes on all autopsies.

*Read before the Children's Hospital Association of America, Minneapolis, Minn., October 14, 1927.

It is desirable to have at least one technician for every twenty-five hospital patients. If the hospital capacity reaches 100 to 125 beds, the technicians should be trained so that each may become especially proficient in some part of the routine, while keeping familiar with all of the technique required. After suitable training one technician becomes the bacteriologist and serologist, another the chemist, a third the technical hematologist, and a fourth the technical histologist. The routine work may be divided accordingly. A diener is necessary to clean glassware, care for the animals, and keep the equipment in order. A director of the laboratory then supervises the work of the technicians, checks all unusual or special findings, directs the technique, introduces new methods, performs the autopsies and correlates and evaluates the results of all examinations.

The director of the laboratory should be primarily a clinician, a diagnostician interested in scientific medicine and familiar with modern methods in diagnosis. Such an individual is of infinitely more value to the hospital than a pathologist, bacteriologist or chemist without the practical point of view. Such an individual is not a "laboratory man," unless by that term we designate a physician like Osler who spent half of his time in the laboratory. The well trained pediatricist of today is able to check and verify the results of his laboratory examinations, including x-ray, and would not practice without these aids. Only such a man is qualified to lead and direct the research and clinical investigation which is one of the most important functions of a children's hospital today.

What the Laboratory Offers

The modern children's hospital laboratory as outlined above will be able to offer the following diagnostic aids: routine examination of cultures of the nose and throat, thus diagnosing diphtheria and diphtheria carriers; routine culture of all discharges, diagnosing diphtheria, gonorrhea, scarlatina, tuberculosis, typhoid fever and the mycoses; routine urinalysis, detecting diabetes, ketosis, pyuria and the other types of nephritis and cystitis; routine blood counts, discovering unsuspected or incipient infections, assisting in the diagnosis of the acute infectious diseases, aiding in the prognosis of the infections and the classifying of the anemias and leukemias and discovering the blood parasites; routine blood tests for syphilis offering inestimable assistance in diagnosis and in evaluation of treatment, and routine histologic examination of tissues and tumors, to determine the pathologic lesions present.

In such a laboratory special examinations can be made, such as blood cultures, which offer the first diagnostic indication in typhoid fever, meningitis of all types except serous and tuberculous, influenza, and sometimes in pneumonias, septicemias, scarlatina and endocarditis; urine culture, to determine not only whether bacteria are present but, more important, the particular type; special blood stains, of value in diagnosing and classifying leukemias and anemias; spinal fluid examinations, to determine the existence and type of meningitis or lesion and the results of treatment; blood chemistry analyses, essential in the diagnosis and treatment of diabetes and of great value in the diagnosis and treatment of the nephritides, tetany, acidosis, intestinal obstruction, burns. Vaccines, serum, antitoxins, and antigens may be made for use in treatment or prevention.

Stimulates Accurate Work

The laboratory as described will offer a favorable milieu for clinical investigation and research and will stimulate more scientific and more accurate work. Our greatest contributions to pediatrics in this century have come from the laboratories of children's hospitals. Among the American hospitals the following have been outstanding in this respect: the Harriet-Lane Home, Baltimore, Md., St. Louis Children's Hospital, St. Louis, Mo., the Hospital for Sick Children, Toronto, Ont., the New York Nursery and Child's Hospital, New York, the Children's Memorial Hospital, Chicago, the Babies' Hospital, Cleveland, the Children's Hospital, Boston, the Children's Hospital, Philadelphia, and the Babies' Hospital, New York.

The recent contributions to scientific pediatrics from the laboratories of children's hospitals have materially altered the scope and function of these hospitals. No longer can the modern pediatric institution confine itself to the mere temporary care of sick children. The institution must accept a far greater responsibility. It must offer opportunities for the study of diseases, thus making a contribution not only toward prevention and more successful treatment, but toward the elimination of preventable illnesses. Convalescing children must be returned to the proper environment so that complete recovery will be assured. The institution must assist in giving every child its rightful heritage to be born healthy and to be kept well.

Finally, with our complete ideal hospital there comes the obligation of teaching. Medical students, interns, general practitioners and physicians preparing for the specialties must be given

the opportunity to study disease as it is found in the hospital, and must be taught pediatrics, diagnosis and treatment, according to the newest accepted methods.

The obligation of teaching demands a select staff of physicians who are willing and able to devote time and energy to the demonstration of their cases. This means that the cases must always be completely worked up and ready for demonstration. After the clinical examinations have been correlated to reach a temporary diagnosis, the student should be taught the laboratory aids that would be of value in establishing the diagnosis, prognosis and treatment. It is not sufficient that a profusion of laboratory work be ordered just to make an impression. Such requests as "complete blood," "complete blood chemistry," or "routine examination," if they make any impression at all indicate a lack of familiarity with scientific procedure. The student must be taught to request those laboratory aids that will be of assistance, he must be taught the normal values, and he should then be sent to the laboratory to observe the tests as they are being made. After such a training the student learns the proper evaluation of scientific procedures, and he will not soon forget them.

When the hospital has accepted these responsibilities, when it is endeavoring to carry out these functions in their broadest scope, then it is no longer a local, provincial institution contributing its part in community service, but an international institute of science, sharing in the development of scientific medicine and promoting the betterment of human welfare.

"An Institute of Science"

Rufus Cole, in an address delivered at the New Haven Hospital, New Haven, Conn., on the occasion of the celebration of its hundredth anniversary, said, "The merchant, Johns Hopkins of Baltimore, was a wise man. What more lasting monument could he have erected than that which he built when he established a hospital in which education and research were to be important functions. Suppose he should have left his money for the establishment of a hospital merely to care for the poor of Baltimore? Most of us would never have heard of Johns Hopkins. As it is, there is not an educated person in this country who does not know of this hospital and is not familiar with the donor's name. The poor of Baltimore have received far better care than would have been the case if education and research had been omitted. And not only Baltimore but the entire world has been made richer and better."

Let me conclude with the words of Osler: "To

wrest from nature the secrets which have perplexed philosophers in all ages, to track to their sources the causes of disease, to correlate the vast stores of knowledge so that they may be quickly available for the prevention and cure of disease—these are our ambitions. To observe carefully the phenomena of life in all its phases, normal and perverted, to make perfect the most difficult of all the arts, the art of observation, to call to aid the science of experimentation, to cultivate the reasoning faculty, so as to be able to know the true from the false—these are our methods. To prevent disease, to relieve suffering and to heal the sick—this is our work."

Is the Dispensary Getting Fair Play?

In an article on "The Opportunity of the Dispensary" by Dr. Cyrus C. Sturgis, Boston, recently published in the *Boston Medical and Surgical Journal*, appears the following passage:

On reflection, it is not difficult to understand why the dispensary has failed to keep pace with the other departments of the hospital. The chief obstacle has been the almost universal attitude toward it which implies that the wards constitute the all important part of the hospital, and the dispensary is worthy of little notice, except as a source of patients who are to be admitted for study or treatment.

Another important fact that has retarded progress is the personnel of dispensary workers. In some instances they are the youngest and therefore the most inexperienced members of the staff, who are attracted to the position only by the lure of advancement to a position on the wards of the hospital. They regard their position as a temporary rather than a permanent one and patiently await the time when their "apprentice days" are over.

The point I wish to emphasize is that the problems encountered in an out-patient department with respect to diagnosis, treatment and general care of patients, often require more clinical acumen and judgment than the management of patients in the hospital wards. It therefore appears logical that the most expert and experienced clinicians should be assigned to this work.

Out-patient physicians are, furthermore, unduly burdened with routine duties, as they are usually obliged to see all the patients who come for examination, whereas the number admitted to the wards of the hospital is limited. The situation concerning the wards of the hospital is desirable, as indicated by the satisfactory results, but the disproportionately small amount of time that is allotted to dispensary patients is amazing. Here the day is crowded with the constant press of patients and there is no time available for other than rather hurried routine work. As a result the dispensary receives but little support, attention or funds, and the uninspired members of the staff perform their duties in a listless fashion.

If this is all that is expected and desired, then dispensaries are functioning satisfactorily. The chief points that should be emphasized, however, are the neglected opportunities in this field and the great possibilities of development in many directions.

The Swimming Tank Is an Aid in Orthopedic Work

By ELLA SMITH

Curative Play Teacher, The Children's Mercy Hospital, Kansas City, Mo.

AT MERCY Hospital we are enthusiastic believers in the water tank as an adjunct to other kinds of curative measures. We do not consider it a cure-all, nor would we be willing to have it replace other methods of treatment that have been found useful. Nevertheless, in one thing the water tank is unique: it wins the cooperation of the patient, which is not wholly lost when the child leaves the water, and which certainly adds effectiveness to other measures directed toward relief.

For the past two years we have been using such a tank in the gymnasium of Mercy Hospital, Kansas City, Mo., and in it our infantile paralysis patients play and exercise with a view to restoration of muscle power. Our tank is of concrete, and represents a number of original ideas that are the outgrowth of Mercy Hospital's years of experience with orthopedic work.

Our smallest and most timid children, on enter-

ing the water, seem immediately assured of safety. Each child is fastened into an adjustable jacket. As you will see in Fig. 1, this jacket is fastened to a bar, which, in turn, is suspended from an overhead trolley track. By means of this apparatus and with pulley ropes, a child can be slowly and carefully lowered into the warm water.

Muscles Are Strengthened

The child seen in Fig. 2 has dangle legs, but fairly good power in his arms. He tries to "make a splash," while the buoyancy of the water and his own confidence in the security of the supporting bands assure him of safety, and his natural instinct impels him to swim. The moment that he is well lowered into the tank he feels that with just the slightest wiggling he can move his hitherto almost useless legs, and at once, and without any fear, he begins to struggle to get

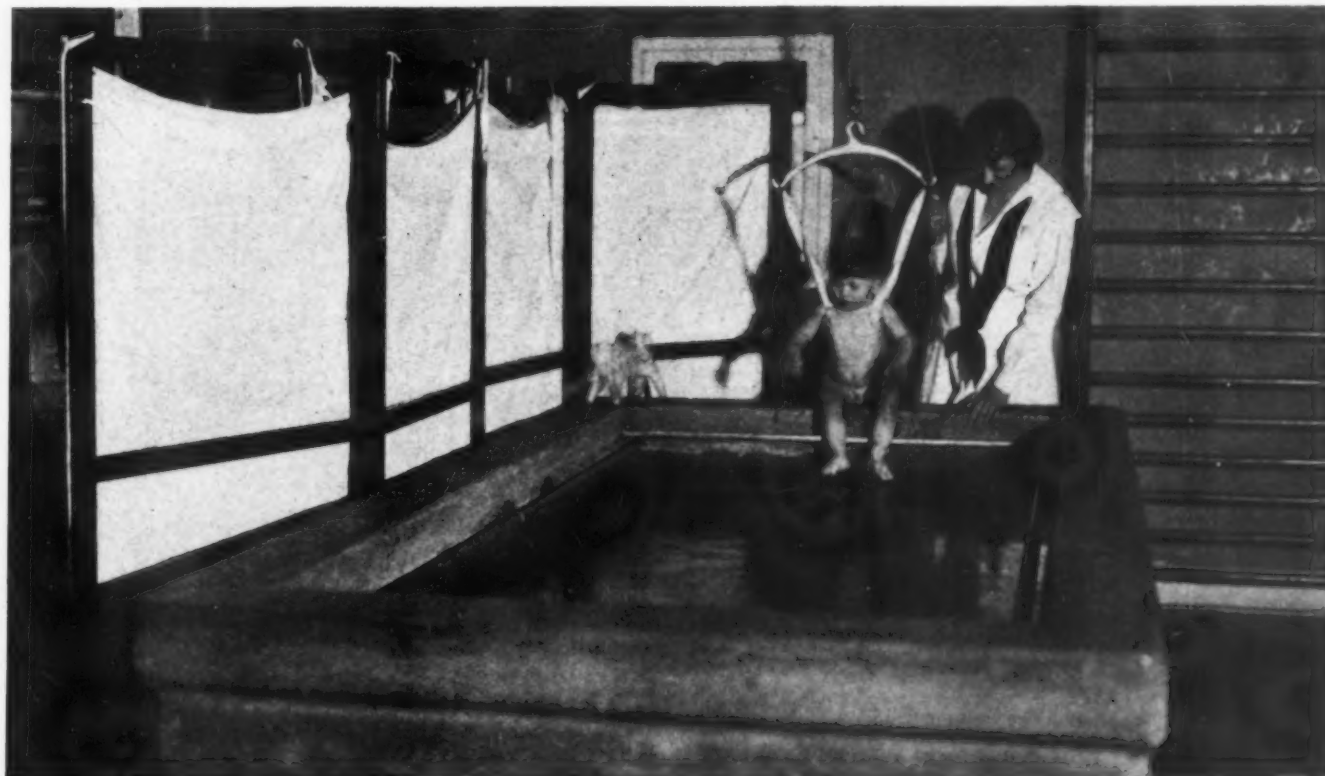
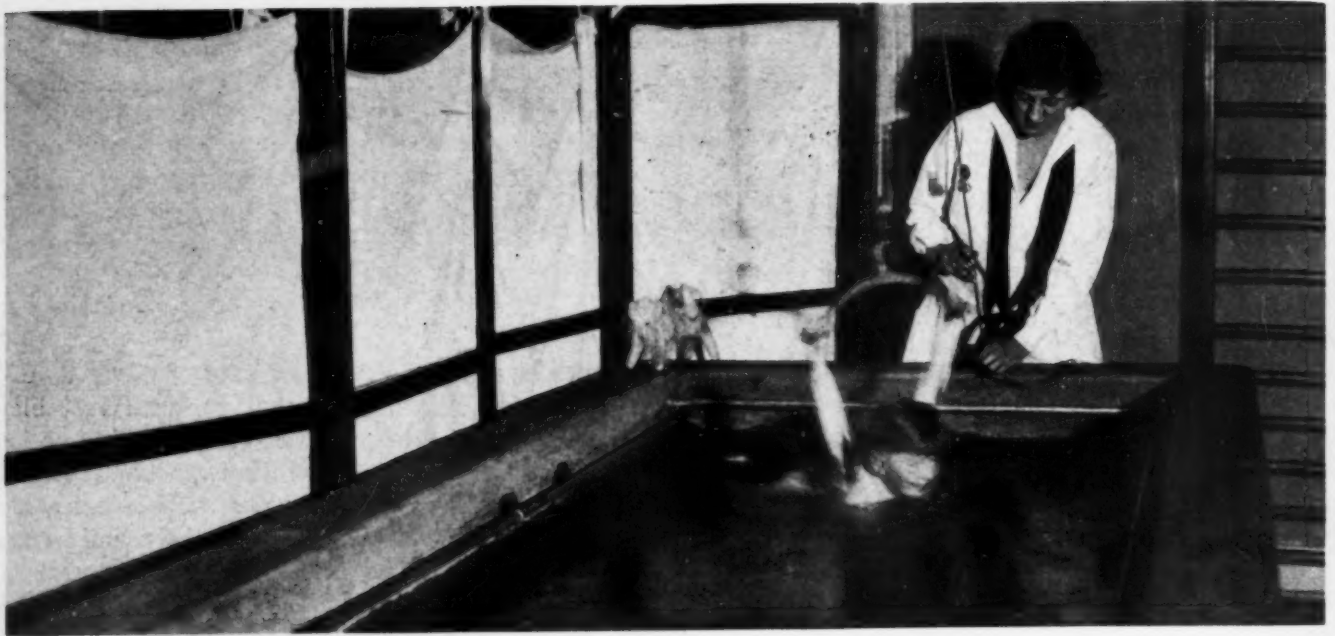
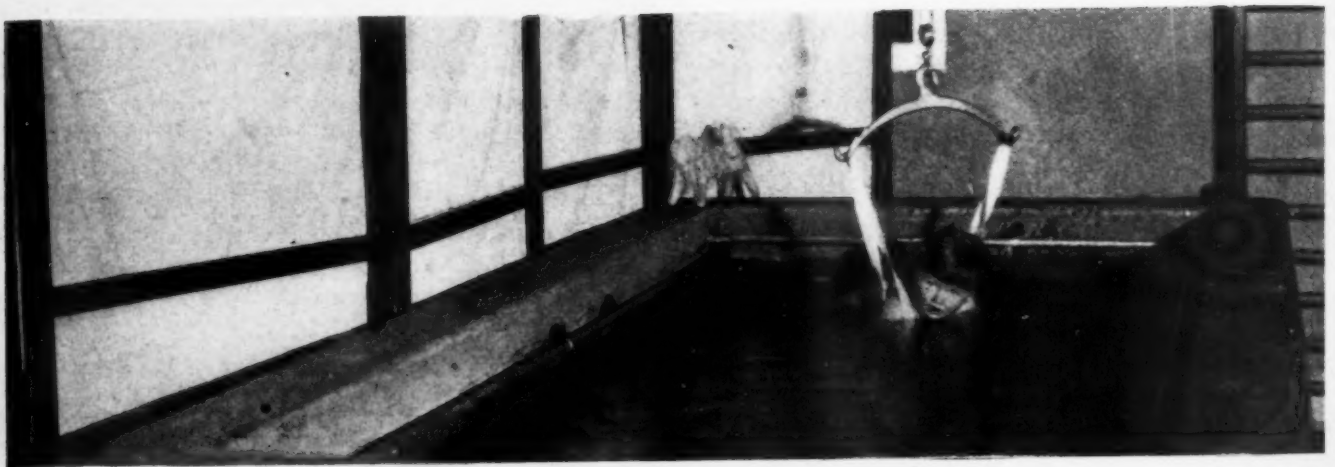
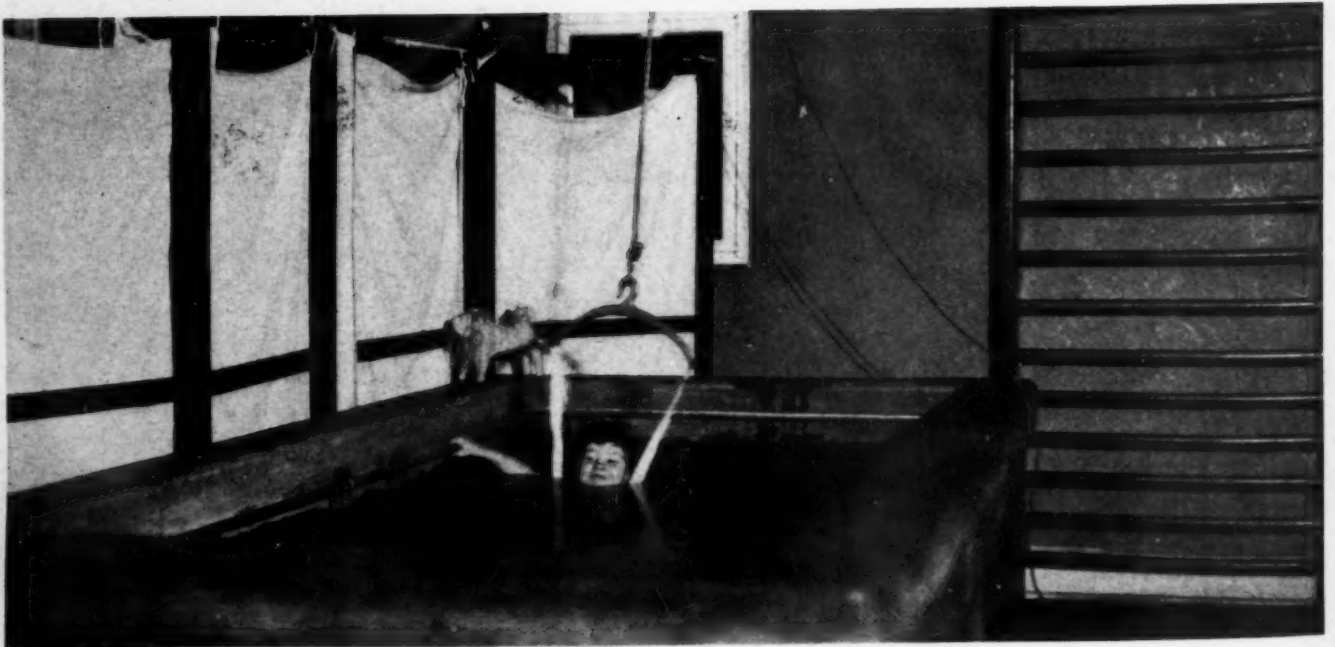
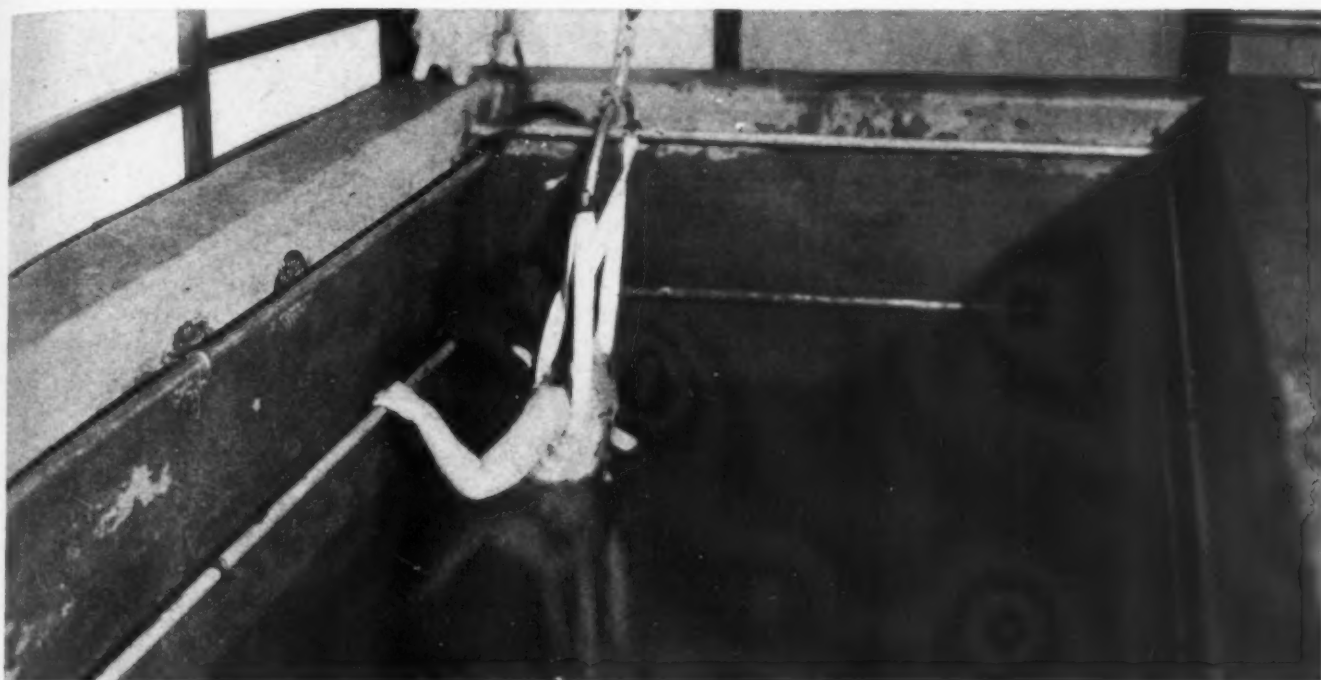


Fig. 1.

*Fig. 2.**Fig. 3.**Fig. 4.*

*Fig. 5.*

across the tank, or to move about in it. The instructor, without his knowledge, may give him a little assistance with the rope, and instinctively he will make use of the iron bar at his side. Since all teachers believe that voluntary impulse is one of the most important things in muscle training, the child's willingness to attempt movement is of unmeasured value.

When a patient is anxious to play "Galloping Horse," and when, of his own accord, he tries to raise first one knee and then the other, progress

in developing muscle tone has more than begun. With careful direction on the part of the instructor, many games may be played and fatigue avoided. It is surprising to see how quickly the movement of weak arms and legs seems to improve, although it is quite possible that much of the apparent result is obtained because the child is making an effort to put into use and strengthen muscles that have never before been called into action.

The greatest factor in bringing about improve-

*Fig. 6.*

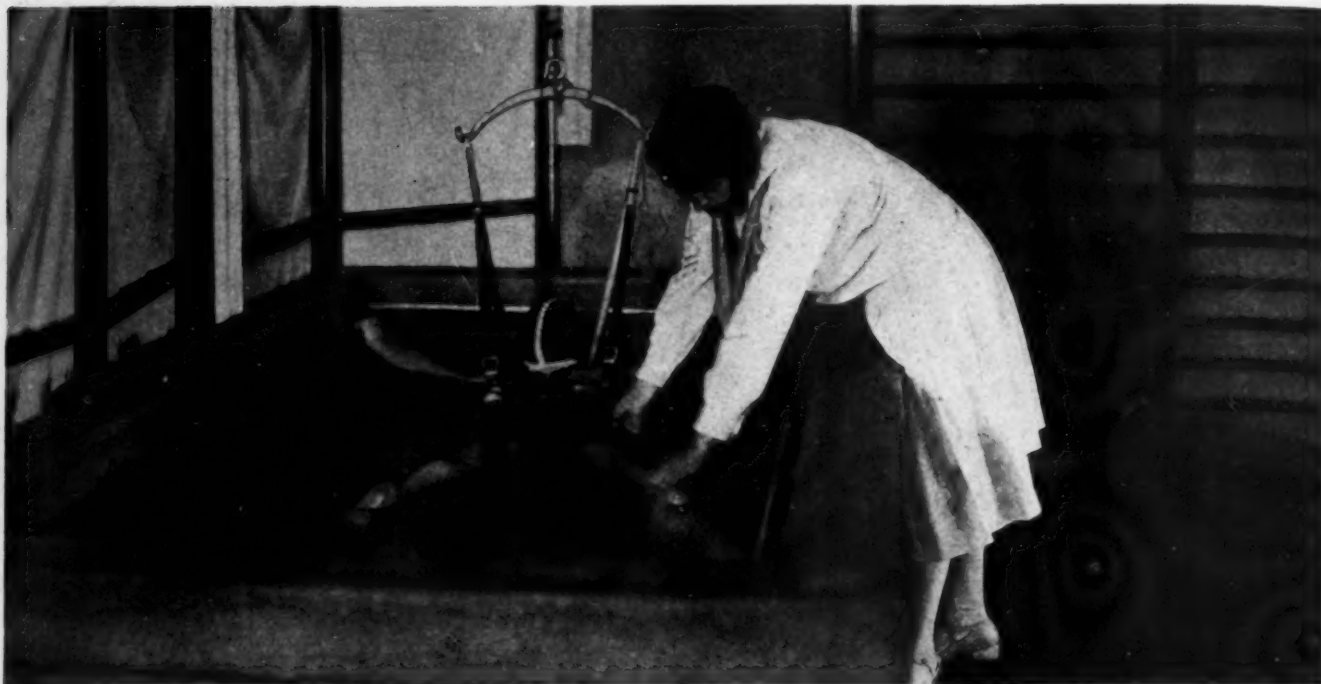


Fig. 7.

ment in the case of a small child is the pleasure that he derives from the various play stunts.

The little girl shown in Figs. 3 and 4 has one totally paralyzed arm, but how she does enjoy trying to "fly under the water," and using the weak arm to grasp for the water pots and toys, while she clings to the iron bars around the inner side of the tank. The more she splashes and tries to use both arms, the more resistance is offered by the water, and thus the muscle tone is helped to increase.

The little boy seen in Fig. 5 has good use of his arms and fairly good use of his left leg. He is attempting to put the weak foot down on the bottom of the tank. In order to decrease buoyancy, the amount of water in the tank has been lessened.

Equally good results are obtained with the older children, who, even when they cannot swim, seem to have the same assurance of safety, and, partially supported by the jacket, appear to have more than the ordinary enjoyment of water games.

The girl seen in Fig. 6 is lying on her side, and flexing her thigh muscles by an endeavor to bring her knee as close as possible to the hand of the instructor.

In Fig. 7 she is seen lying face downward, grasping the bars and exercising the hip muscles, the knee being held firmly by the instructor, while the complete arc of motion is being made without other assistance.

Many infantile paralysis cases, with weakened muscles in arms, legs and back, have, while with

us, learned to swim without assistance, are continually trying to perform feats of swimmers.

Altogether, we should be most unwilling to do away with the water tank help.

Safeguard the Hospital from Fire

The Jewish Hospital, Cincinnati, has a copy of its fire regulations posted at various prominent points throughout the building. Here's the way they do it:

FIRE REGULATIONS

All fires should be reported to the telephone operator, who will immediately give ten short rings on the phone in the porter's quarters, nurses' home and interns' quarters.

In responding to the alarm, the phone operator will direct where to go.

Fire extinguishers will be found on every floor in every building.

To use fire extinguisher, turn upside down, and turn hose on fire.

Every effort should be made not to alarm patients.

Nurses should visit each patient and assure him there is no danger.

If the fire is beyond control, someone in authority will direct the phone operator to notify the fire department.

It is the duty of every intern, nurse and employee to respond to the ten bell alarm and render all assistance necessary. Fires can be avoided by:

Adherence to no smoking rule.

Care that rubbish and oiled rags are removed.

Careful handling of paints and combustions.

Care in handling lighted lamps.

Your cooperation is imperative.

Signed, LOUIS COOPER LEVY,
Superintendent.

How One Hospital Provides Books for Its Patients

By MRS. ROGER S. SPERRY

Waterbury, Conn.

THE fiction library of the Waterbury Hospital, Waterbury, Conn., has been functioning for four years and has proved successful. It is run by the Junior League and it cost slightly less than \$100 to set it up because the hospital gave a room and shelves, a table and a scrap basket.

The library was organized by one who was sympathetic with the hospital point of view but who had no library training. We think one of the refreshing aspects of the work that the patients enjoy, is the sight of bright young girls in cheerful green smocks, who, with no literary pretensions, smilingly offer their books or push the cart closer to the bed.

As for the books themselves, once in a while we reject a volume sent in, as not suitable, but the patient as a whole has to take a chance that our books are of a type that will be good for him.

We designed our own book cart, saved considerable money and, we believe, improved on present stock models. It is high enough so that a patient can make his own selection although he is in bed. It is narrow enough so that it goes easily between the beds in the wards, and patients can select books from each side. The wheels are the finest we could buy, absolutely quiet, the same as are used on the hospital trucks. They cost about \$5 each and they are worth it, for they permit us to turn our cart, very heavy when loaded with some two hundred books and magazines, in a small space, without physical strain. Our cart cost a little less than \$40.

When the patient makes his selection we put a fresh green wrapper on every book. These keep the books clean, and make it easy for us to identify our own volumes when we enter a room. The covers are given to us by a firm



Members of the Junior League with their library, at Waterbury Hospital, Waterbury, Conn.

which runs various advertisements on them.

Our cataloging is the simplest possible. We have a "taken and returned" slip pasted in the back of each book and cards on rings between stiff cardboard form our catalogue. On each card, below the title and author of the book, we have a space for the name of the patient, his room number and the date the book is taken and returned. The books on one side of the book cart have a red spot painted on the back. We tried stickers, but in the dry, hospital atmosphere they dropped off even when lacquered on. The books on the other side of the cart have a blue spot, this is, each book has either a red or a blue spot, on the back. The cards are between covers of corresponding colors hanging on hooks between the shelves on each side. This enables two girls to charge or discharge books at the same time. This system permits us to have two catalogues but prevents a book being charged in one catalogue and discharged in the other since each book is found only under its own color. The girl who gives out books direct from the library ignores these colors as she is the only one there and her catalogue contains every book.

Book Plate Pleases Children

One of our girls designed a book plate, which the children especially enjoy. There is no limit to the number of books a patient may take or the time he may keep them. If a patient goes home before we collect his books he leaves them, and if some one else is reading them we are pleased. Public libraries lose hundreds of books a year and we feel that we can spoil the spirit of the whole idea if we fuss too much about losing a few books.

Four years ago the Junior League collected several hundred books in four days and they are still coming in from the league, from patients and from friends of the league who are interested and who, of their own accord, offered them. People give away modern fiction quite readily.

We have a magazine committee that collects all magazines not more than one month and five days old, by the fifth of the month, and takes them to the library. We keep no records of these. Once they are on the floor the patients pass them on to each other.

We do not permit the nurses to take any books from the book cart but they can get them from the library. On their books we put lavender covers. Because we know how difficult it would be to check the nurses' books, we set a two weeks' limit, with the privilege of renewal. We told the girls if they failed to return the books they would be posted once. If within the week the books did

not appear, we should be regretfully obliged to discontinue this service to all the nurses. They are still getting the books.

I have purposely avoided figures but I have been told that one should have three times the number of books that there are patients in order to start a library. Each year we eliminate the older books and the duplicates, thus keeping our fiction library up to date.

A hospital is a busy place and hospital managers dread intrusions. They have no time to bother with outside affiliations. Nevertheless, it has been our experience to find that our managers had their patients' welfare and contentment at heart and since we offered them our idea, well thought out, it was easy for us to convince them that we had a benefit to offer, and they have accepted us eagerly, even though they had previously had a library experience that was not successful. Many hospitals have libraries but not so many have the recent modern fiction.

Social Worker Is a Link Between Varied Activities

In speaking on the hospital social worker in her varied relationships, at a meeting of the Michigan State Conference on Social Work, held at Ann Arbor, Mich., Mrs. Constance B. Webb, director of the social service department, Lakeside Hospital, Cleveland, said that "the patient, the necessary center of all hospital activity challenges us to see him as a whole person, to interpret his needs to himself and to others, to educate him in health matters and in social adjustment and through him, those about him.

"Our responsibility to the doctor, the final authority on questions of medical care and health, is to understand his aims and methods, to contribute, if may be, to his fuller knowledge of the patient, and to work as his side partner with his patient.

"It is essential that in our relationship with the administration, the pilot of the ship, the directing force, that we fit in smoothly, contribute helpful information when possible and appreciate the composite viewpoint of other departments.

"With the cooperating agencies, those supplementary forces in the patient's rehabilitation, we have the opportunity to share our knowledge freely, to exchange facilities and to develop them."

Standardized Dressing Trays Are Time Savers

The standardization of dressing trays within the hospital has proved satisfactory to the staff of St. Joseph's Hospital, Victoria, B. C. Before the trays were standardized, the doctors, on their daily rounds would often find need for some special instruments or ointments which the particular dressing tray at their service might not contain. In order to procure the necessary article both time and energy were wasted, so it was decided to equip each tray identically, and as completely as possible.

Selecting Nurses for Mental Hospitals*

By ESTHER HART-STONE, M.D.

Senior Physician, Peoria State Hospital, Peoria, Ill.

THE choice of nurses for mental hospitals in the state service, once a serious problem, is no longer considered so. It is now an established fact that the choice of a nursing personnel is an evolutionary process governed by the law of natural selection, and the survival of the most fit.

With the advance in knowledge and in the scientific care of state hospital inmates, the need for an adequate nursing force of well trained, intelligent women, became imperative.

Forty to fifty years ago, no such problem existed. The state hospital attendant of that period in no way compared with the attendant of today. The attendant of that period stood in relation to the patient in the light of a keeper or overseer. The attendant then was not chosen because of any particular fitness or personal aptitude, but because she was often fit for nothing else. She was not questioned as to her ability, standing or moral fitness.

Abuses to Patients Were Common

Only an insane asylum would permit the various abuses to patients that result when persons of that caliber are in positions of authority. Often, these women were of the lower strata, sunken in vice and degradation, willing, for a paltry sum to exert their vile influence over the unfortunate. These types were a necessary evil; there were no other applicants for these positions. The care given patients was brutal in the extreme. They were herded, isolated, starved, flogged, kept in filth. Their keepers were the sole arbiters of their fate. These are facts and matters of record.

The attendants of that period, however, should not bear all the blame. They were merely carrying out the orders of their superiors. My indictment includes heads of the commonwealth and also the public who tolerated these evils, and when remonstrated with sought refuge in precedent and in inherited beliefs that the insane could be cared for in no other way. The occasional weak voice of the reformer was like a voice in the

wilderness, unheard or soon forgotten. No permanent improvement in methods of care could come until changes were sanctioned by governing powers as a result of the persistent agitations for reform sponsored by certain great men and women who saw and realized the need for caring for the afflicted in a humane way.

Little wonder then, that these historic times have left their mark, so that even now the term "insane asylum" is connected with things dark and sinister. Irrespective of the progress made in state hospitals, visitors still ask to see the padded cell and the dark chambers.

How Reform Developed

The process by which the old asylum keeper has been displaced by modern nurses, drawn from well organized and well equipped nursing schools, is an evolutionary one. Progress in medicine and surgery has gradually and persistently developed and has finally penetrated the dark walls of asylums, although the steps taken were necessarily slow and halting. The first step in this great reform began when an attempt was made to segregate the physically infirm from the more healthy subject. Thus arose the infirmary ward. The person usually selected to supervise this ward was one who had some slight knowledge of the care of the sick. At a much later period surgical relief was introduced in cases where the need was indicated. It was then that the trained nurse became a necessity. It was at this time that the nucleus of the future hospital training school was established. And so, from the very need of it, the nursing service evolved.

I am particularly familiar with the modern state hospital training school as first established at Peoria State Hospital, Peoria, Ill. Dr. George A. Zellar, the superintendent of that hospital, always in advance of his time and a pioneer in all reforms that tend to improve the care and humane treatment of the mentally sick, introduced special courses for attendants and nurses, so that the sick might get the benefit of intelligent nursing and treatment. He abolished all forms of mechanical restraint and introduced comforts com-

*This is the fifth of a series of articles dealing with the problems of hospitals for the mentally ill.

patible with the needs of the patients. And although our progress has necessarily been slow, we are now proud to say that good nurses, well trained and equipped for this service, are now the rule at Peoria State Hospital.

The choice of nurses for entrance into our training school is governed by two conditions: first, personal qualifications, namely, intelligence and ethical standards; second, educational advantages of a type that will enable the student to carry the course of training without difficulty. Four years of high school are a prerequisite of entrance to this school.

It has always been my contention that a good nurse is born and developed; therefore, the good nurse must have a satisfactory background as well as good training.

How Can We Retain Our Nurses?

The problem that confronts all training schools is how to keep the nurse in the service after she is secured, trained and made useful. There are many greater opportunities for good nurses, and that they should seek to fill places of higher responsibility is quite natural. Those who disappoint us most are the nurses of promise who leave the state service on completion of their training. An effort should be made to keep the nurse satisfied and to retain her service after effort has been expended upon her training.

On the other hand, few young women enter the service with a view to making it their life work. In my years of association with nurses during their training, I have often tested their reasons for taking up the work. Some of their answers are illuminating. They take up nursing because, "I have to work;" "Because I need the money;" "Because it leads to something better;" "Because I think I like it;" "Because it offers greater opportunities for women;" "Because it gives one some prestige;" "Because of personal pride and a desire for self-improvement." All these are justifiable motives, no doubt, but I do not recall one who made the statement, "Because I want to make it my life work;" "Because I want to devote my life to the interest of the sick;" "Because I can do the most good in this line." Even the best students, those who stood high in their classes and in their work, gave no such reason as the motive that led them to take up nurse training.

The most successful nurse, in my estimation, is the one who devotes her life to nursing, and has no other outlet, such as nurses of special orders who devote their entire life to service. The nurse of the future, the one who will stand by the patient and finally lead him from paths of danger to a

safety zone, will need only two qualifications, namely, loyalty and devotion to service. Such a nurse, a direct and devoted emissary of the physician, an angel of mercy to the patient, and a bulwark of strength to the agonized family, is the finest gift of God.

In this day of specialties and multiple divisions of the human body, the nurse alone must understand and care for the integrate organism. For her there must be no dividing line. She must understand that a physical ailment may produce mental symptoms, and that mental ailments may give rise to physical conditions. She must care for the individual sick person. Upon her, next to the doctor, devolves this responsibility.

With her growth in knowledge and usefulness the state hospital nurse of today demands and earns more privileges. The old-time army discipline regulating the life of a state hospital should be modified by a more social atmosphere after the day's work is over. The extreme social gulf that existed between higher officials and subordinates should, with other time-honored and obsolete measures, be thrown into the discard. A mutual feeling of respect and confidence should arise between persons who work for the welfare of the patients and should gradually replace the old, stiff unfriendly attitudes.

During and after training, the nurses' health and comfort should be safeguarded, and even her recreation should be planned and supervised as much as possible. She should feel that a keen interest is taken in her welfare and that she is not merely a necessary appendage. There should develop a common interest between nurses and superiors in office. The nurse should feel free to go for advice and guidance to her superiors and she should feel that her interests are safeguarded.

The nurse of tomorrow must be an intelligent, well trained, social being, firm in her belief that devotion to service is the crown of her labors.

Where Does Sickness Begin?

In an article on the "Care of the Sick" recently published in the *Canadian Nurse*, Dr. David Stewart, medical superintendent, Manitoba Sanatorium, Ninette, Manitoba, writes:

"If all illness is to be carried without question by the community, it will often be very hard to decide just where health stops and sickness begins. Few are one hundred per cent ill, and none of us are one hundred per cent well. Every doctor knows that in hard times especially, a differential diagnosis has often to be made between sickness and unemployment, or sickness and imagined sickness, or sickness and a chronic disinclination for work, or sickness and some complex of circumstances that sickness would provide a welcome escape from. It is wonderful what persistence and ingenuity will do in establishing a malingerer as a public charge."

How Do You Buy?

By ARTHUR E. ALBRECHT

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MARKETING may be considered from the viewpoint of the producer, from the viewpoint of the buyer or from the viewpoint of the economist. The producer is interested in marketing and looks upon it as a method of disposing of his goods. The consumer looks upon it as a method of buying goods. The use of the word "marketing" from these two points of view may be illustrated as follows:

When the farmer says he is going to market, he means that he is going to sell his goods or produce. When a housewife says she is going around the corner to the market, she means that she is going to the store or city market to make her household purchases.

The economist is primarily interested as an examiner of the marketing process and tries to contribute useful information to both sellers and buyers. In the past almost all the attention that has been given to marketing has been from the viewpoint of the producer, either the farmer or the manufacturer. An indication of this is the number of textbooks that treat marketing with the farmer or the manufacturer in mind.

Only recently has the buyer for the household or the buyer for hotels and hospitals been given attention by writers who discuss marketing. An examination of the files of hospital magazines and magazines for women indicates that where food is touched upon, it is considered mostly from the standpoint of preparation and cooking. Only within the past few years has attention been given by hospital publications to the problem of selecting and buying food.

Marketing Problem Arouses Interest

The recent interest in marketing problems has been due to increased living costs, and since living costs are primarily food costs, much attention has been given by the U. S. Department of Agriculture and by progressive state departments of agriculture to the marketing problem. For example, the cost of various articles of food throughout the United States as reported by the United States Bureau of Labor Statistics is now 50 per cent higher than in 1913. The buying public as well as farmers have suspected that large distributive margins existed and that in some way or another the cost of handling could be reduced. As a

matter of fact, the exact margins are known for only a few commodities, as little statistical work has been done in the direction of ascertaining the cost of distribution.

The public interest in the marketing problem is manifested by the recent increase of legislation covering such topics as cooperative marketing, cold storage, grading and standardization. In the State of New York, for example, a law was recently passed relating to the selling of eggs, and the department of agriculture and markets of that state, in accordance with that law, has established five specific grades for the purchase of eggs at retail. It is expected that the enforcement of this new law will improve the quality of eggs put on the market and will be of direct benefit to hospitals and other institutions that buy eggs in large quantities.

In this connection it might also be interesting to recall that the U. S. Department of Agriculture has established over forty grades for various fruits and vegetables.

Buyer Must Know Current Prices

Large businesses have found it advantageous to add purchasing agents to their staffs; so, too, many large, progressive hospitals have found it desirable to have their buying centralized in one individual who knows foods and who has some knowledge of marketing conditions. Such a purchaser must be informed of current market prices and conditions and must know how to buy accordingly.

In many states, current market prices and conditions are made public by departments of agriculture which send out reports by mail, over the radio or by publication in the daily newspapers. Purchasers should get in touch with their department of agriculture at their state capitol, to find out what reports on market prices are available to them. They should also get in touch with the U. S. Department of Agriculture, Washington, D. C., for similar information made public by that department, which has an excellently developed system of market reporting.

Purchasers should also be acquainted with standards of quality, and should make certain that they get from the merchants the quality they order. They can secure such protection only if

they are familiar with the qualities of goods. Here also the publications of the U. S. Department of Agriculture dealing with the grades and standards of fruits and vegetables, meats and eggs can be used to advantage.

In addition, the excellent textbook recently published by Day Monroe and Lenore Monroe Stratton, entitled "Food Buying and Our Markets," should prove helpful. This book not only gives suggestions for the purchasing of specific foods, but also acquaints the reader with the marketing of goods.

Check Deliveries

To make certain that the correct quantity of goods ordered is delivered, deliveries should be checked on arrival and notations made of any shortage. Many institutions find that leakages are stopped when this precaution is taken. Attention should also be given to the proper care of goods after delivery, so that they will not be improperly used or allowed to spoil while in storage.

One of the great needs of present day industry is the simplification and standardization of goods. Much progress has been made in this direction by the U. S. Department of Commerce which, in cooperation with business men, has standardized and simplified many commodities. Among those of special interest to hospital executives are the following: beds; springs and mattresses; bed blankets; cafeteria, restaurant and hospital chinaware and steel lockers.

The development of national standards for farm products has been a process of evolution, as established trade practices yield but slowly to change and improvement. Such changes as do occur are largely the result of economic necessity. As early as 1914 cotton was definitely standardized, and in 1916, standards for grain were established by the U. S. Department of Agriculture. Since that time, progress has been made in the standardization of fruits and vegetables, honey, meats, wool, butter, cheese and eggs.

I believe that the development of standards will do much to bring about a better marketing system. The wider standardization of commodities will be of use not only to producers, but to the buyers of food and other commodities.

Learn from Departments of Agriculture

To secure for hospitals the advantages of this standardization and to place hospital buyers in the same position as buyers in the wholesale markets, hospital purchasers must become familiar with the grades of the U. S. Department of Agriculture and those of their state departments of agriculture. In this way purchasers

will be enabled to save much time and much money.

The buyer who knows grades, can order without inspection, can make intelligent price comparisons, can order in advance for special occasions and can save money through buying the exact quality needed. Buying by wholesale merchants is done by grades, because these buyers insist upon efficiency in their buying. An example will illustrate this:

It saves time for all food distributors to be able to procure what they want without a detailed examination of each basket or barrel of goods. Ordering by mail or telegraph is made possible through grading. No wholesaler would telegraph from New York to Kansas for ten cases of good eggs, because the word "good" has such an indefinite meaning. If he were to ask for ten cases of freshly gathered, extras, brown eggs, medium size, he would know what to expect on delivery.

Standardization Is Needed

It has been aptly said that standardization takes the mystery out of marketing because standardization gives a definite picture of what is actually being marketed. Compare the present day system of paying bills, with the unstandardized money system that prevailed in this country in Colonial times. Each bank issued its own paper money and each state issued its own metallic and paper money. Under such a confused monetary system, merchants frequently referred to a chart before paying out or receiving money in order to ascertain its current value. Today such a confused system would not be tolerated.

The terms "pound" and "ounce" also mean something very definite to us. Our system of weights and measures was wisely standardized early in the history of this country. And if money and weights and measures have been standardized to the advantage of both buyers and sellers, why should not our fruits and vegetables and eggs be standardized?

How Money Is Lost

Each year the buyers of this country are cheated out of many millions of dollars because the containers in which they buy their fruits and vegetables have not been sufficiently standardized. The chief difficulties are with the market basket, the hamper and the round stave baskets. The market basket is largely used by farmers at retail farmers' markets. A survey of the U. S. Department of Agriculture has shown that 50 per cent of the market baskets in use have a capacity of from thirteen to fifteen bushels, while the purchaser believes that he is receiving a sixteen-

bushel basket. Here the short measure package has been substituted at the full measure price for the standard sized container.

Fifty Different Sized Hampers

The hamper is a container with sloping sides that is wider at the top than at the bottom. It is shown in the accompanying illustration. The hamper is made in fifty different sizes, and the persons buying the half-bushel hamper and the one-bushel hamper are frequently imposed upon by having shorter measure hampers substituted. The two hampers illustrated show the difference between the contents of a fourteen-quart and a sixteen-quart hamper.

A third type of container that is a frequent offender is the round stave basket. This comes in twenty different sizes. This container consists of thin staves and generally has a rounded bottom. Buyers are asked to beware of the alleged eight-quart, sixteen-quart and bushel baskets, and when deliveries are made the containers should be carefully inspected.

As the short-weight containers are so made as to look somewhat like the full measure containers, buyers are frequently deceived without knowing it. The best protection is to look for the stamp of the contents on the container, which is required by federal law on containers that enter interstate shipment. The laws of many states also require such marks.

Limit Variety of Containers

Purchasers should accept only containers of standard size. It might be well to have hospital executives endorse at least the principle of further standardization and encourage such steps as the departments of agriculture and commerce are undertaking to standardize containers. In this connection, it is of interest to point out that barrels, grape baskets and berry baskets have already been

standardized by federal legislation and that bills have been introduced into Congress for the standardization of the market basket, the hamper and the round stave basket in harmony with the recommendations of the U. S. Department of Agriculture, which proposes that the number of containers be limited to those sizes that can be easily distinguished and recognized. For market baskets the Department of Agriculture recommends six sizes, and for hampers and round baskets, seven sizes.

Federal Legislation Needed

As the manufacturers of these containers are widely scattered throughout the United States and are not united in an effective trade association, voluntary standardization will probably be ineffective and it will undoubtedly be necessary to standardize the containers mentioned by means of federal legislation. If hospital superintendents and purchasers will assist the U. S. Department of Agriculture and the U. S. Department of Commerce in further standardizing the commodities they buy and the containers in which they come, much money will be saved to the institutions and much time and trouble will be spared the buying agents.

As the ultimate solution of our political ills is an informed body politic, so, too, the solution of our food marketing problem depends upon a clearer understanding of a marketing system by institutional as well as by individual consumers. The first step toward a better understanding of our marketing problem, I believe, is an appreciation of what is involved in the further standardization of food and other commodities. Purchasers should avail themselves of the publications and the services of the federal departments and the state departments which are doing so much to simplify our complex marketing system and to aid those who buy.



The two hampers look alike but the apples on the floor represent the difference between the contents of the fourteen-quart and the sixteen-quart hamper.

Yet Another Conclusion Regarding Costs and Charges

By JOHN D. SPELMAN, M.D.

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THAT the economics of hospital administration has made rapid strides cannot be gainsaid, and hospital administration, generally speaking, has reached the state of development wherein pretty nearly every hospital worthy of the name in our country today is producing a dollar's worth of service for every dollar expended.

If we are to justify the increased cost of hospital service today as compared with that of former days, we shall have to analyze this service from two standpoints: first, the effect upon it of the rise in cost of both labor and materials and, second, the elements that compose hospital service, to see whether certain services rendered by the hospital today, and not formerly rendered, are necessary to the patient.

I do not believe that the first proposition is at all difficult. Only a cursory examination is needed to make clear the fact that the difference in the purchasing power of the dollar since the last war has affected the production costs of hospital service in no greater degree than it has affected such costs in any other field. In fact, the hospital labor market has not increased in cost as much as other labor markets, because the salaries of hospital employees have not increased in proportion to the salaries of other activities in which the middle class of our citizenry are engaged. Only too many members of our hospital organizations receive as a supplement to a comparatively small salary, either the opportunity for training or the stimulation that comes from doing worth while jobs in a worth while way, for the benefit of their fellowmen.

Hospital Service Now More Elaborate

Much has been written upon the subject of the elaboration of hospital service and the introduction of the newer elements with which the hospital of former years did not have to concern itself. We shall all admit that a hospital would be vitally affected by a financial crisis, and we should be loath to admit our part of the responsibility for it, although we claim to be one means of improving the economic status of society by reduc-

ing absenteeism from industry, through the prevention and cure of disease.

In former days hospitals had little weight, constructively, in the minds of the people and, while it cost but little to produce a day's service in a hospital of the medical boarding house type of that day, such a hospital was markedly lacking in popularity in spite of the low cost of service, because it ranked as a place to go to die in rather than a place in which to get well.

Hospital Population Increases

The trend of medical practice, away from the bed in the home, into the offices of the doctors and into the modern hospitals of today, is due, first, to the education of our people to the acceptance of the fact that more frequent medical consultations before the incapacitating stage of illness has been reached are conducive to improved economics as well as to increased happiness; second, to the development of medical science, which has brought into the practice of this science new complexities that the individual physician alone could not capably meet.

We have now reached an age of medical team work that requires the attending physician to be the director and coordinator of the work. Working with him are the members of a large family of professional and technical personnel, such as can be found only in the hospital of today. Their presence has created an increase in the hospital's pay roll. The equipment necessary for their work and the space needed to house these new activities constitute further increases in the cost of hospital operation. This may be an age of specialism in medicine, but in the last analysis, the hospitals, whether they are analyzing the cost of the production of their service or justifying the maintenance of their ideals of hospital service, must realize that they and they alone are supplying the equipment and personnel required for the medical team work of today.

No hospital has a proper conception of its functions that does not object to unnecessary work from those laboratories whose sole function it is to aid in diagnosis. It would be shortsighted for

any hospital administrator to decide arbitrarily whether a doctor, regardless of production costs, shall, for instance, order routinely stereoscopic studies of the chest and Bucky pictures of the abdomen as part of the study of each patient coming under his care. The activities of our hospitals are intimately bound up with methods used in the practice of medicine. Hospitals should conceive it as their sacred duty to exert a benign influence on the development of new methods, disregarding whenever possible the obvious fads in practice that spring up from time to time. They should lend aid in the development of any new ideas in medical practice that are justified by the consensus of opinion of the best medical minds.

It is generally agreed that all the advantages of hospital service are enjoyed by two extreme groups of society—those who can pay for all they require, and those whose condition justifies the acceptance of service without charge. There is no question but that the backbone of our citizenry, the large middle class, is entitled to the same service as the other groups receive. An institution motivated by high ideals of hospital service, with its inevitably high cost, should, through the self-same ideals, accept its sacred stewardship toward the middle class. The institutions that are dispensing charity are doing so through a high conception of their duty in serving the community. This same conception of duty calls for the highest ideals in dispensing charity, a procedure properly defined today as giving the individual whatever he needs, and charging what he can afford to pay.

Educate the Public

I am not sure that even in Utopia we should desire the expense of medical service to our middle class to be "painless." It is human to prize most that which requires some effort to obtain, and while it is of primary importance to prevent financial hardship in meeting the cost of hospital service on the part of our middle class, it is equally important to keep in the minds of this group a sense of values regarding it.

The part-pay service that is rendered by the hospitals of this country is a material and positive answer to the problem of the cost of hospital service in relation to the individual's ability to pay. To those paying the rate of \$2.50 for service that costs \$5 or \$6 per day or more to produce, it affords a definite solution of the problem. While it is many times apparently a hardship for an individual to pay even as low a rate as this, it should be realized that the same individual is often not averse to paying an equal cost for things less necessary than hospital service, such as recreation and amusement.

Furthermore, it is a fact that in the less expensive private rooms of almost any hospital the rate of charge is directly comparable with the rate of charge in our hotels for lodgings without meals and with a minimum of service. In addition to the highly technical and professional services of the laboratory; the dietary and nursing departments; the medical record departments; and a house staff, the public demands from the hospital expensive facilities for giving information, handling visitors and rendering other services.

It is true, to be sure, that we go to a hotel primarily because we want to, whereas we go to a hospital because we have to. The psychology is different; nevertheless we should realize that the figures total exactly the same on the budgets of household expense, regardless of this psychology of approach.

Let us reduce the whole thing in terms of averages, and take from amply available statistics something of the number of days of hospital service that the average family requires each year. Let us also consider the actual expenditure of the average family for medical service. We shall find, I believe, while the cost of hospital service will always pinch, coming as it does unexpectedly and outside of the provisions already made for expending the family income, that the expense is not too great to be met by the family budget, with slight adjustments in the planned expenses for recreation, amusement and the frills and furbelows that modern fashion dictates even to the middle class.

If, then, some of the increased cost of hospital service is due to the frills and fads of modern medical practice, cannot we of the middle class afford to indulge our medical service in the privilege of these fads as we indulge ourselves in the modern fashion in dress? The average family is said to expend \$80 per year on medical service. I am sure it spends a great deal more than this for clothing.

Physical Therapy Departments Are Increasing

In 1925 there were only twenty-four hospitals having a department of physical therapy, as contrasted with 301 in 1926. The committee on hospital standardization of the American College of Surgeons has recommended but does not require a physical therapy department for every hospital, supervised by a full time medical physiotherapist. The American Hospital Association advises every hospital to secure a well trained medical physiotherapist and authorize him to decide upon such matters as space, installation of equipment, supervision of personnel and technique.

STUDIES ON HOSPITAL PROCEDURES

Organization of Hospital Social Service*

"A PATIENT, in the last analysis, is only a human being incapacitated, or threatened with incapacity, physical or mental. He represents the cross section of a human life and as such is the resultant of many forces in the past—hereditary, industrial, environmental, economic, social—which may have conspired to predispose or contribute to his present condition. It is frequently quite as necessary, then, to understand and to interpret these human and social factors as it is to appraise technical and biological factors in order to secure a correct diagnosis, to guide treatment intelligently and to propose methods of prevention."

This quotation from the report of the American Hospital Association's committee on the training of hospital executives thus recognizes the patient as "the unit of operation of the hospital about which the whole organization should be built." The patient is here seen, not merely as an occupant of a bed, nor as interesting clinical material, but as an individual. It is on this aspect of the patient that the hospital social worker focuses her interest and attention.

In the article in the March issue of *THE MODERN HOSPITAL*, "Some Basic Principles in Social Service," we concerned ourselves with the first essential in the organization of a social service department, namely, the necessity and the function of social case work as applied to the patient in the modern hospital. It was demonstrated how organized medicine tended to break up the unity of consideration of the patient, and shown that the personal and social consideration of the patient could, in part, be restored by the skilled social worker. We are assuming that she is a social worker equipped with the skill and special knowledge, worthy of association with a high quality of medical case work, and with such knowledge of the physicians' methods and viewpoints that she can, with discrimination, bring her special skill to the personal problems of the patients.

*A study prepared for *THE MODERN HOSPITAL* by Ida M. Cannon, chief, social service department, Massachusetts General Hospital, Boston.

We have recognized the fact that when sickness comes we have not only a bodily disturbance, but what may be even more painful to the patient's spirit—a break in the continuity of his normal activities. We also assume that the factors indicated in the above question are of such fundamental importance that in all hospitals where they are not fully understood and ascertainable by the physician at first hand, there should be associated with him one who is free to give time and thought whole-heartedly to the personal and social problems of the patient.

We recognize the fact that the function of medical social service is inherent in medicine itself and that the patient is the entity for study and treatment, not the disease.

Recognizing the scope of the social worker's action in the hospital, we may discuss the principles and methods that should guide the relationship of the social service department to the other departments in the hospital organization and the sources of responsibility and authority.

The prime responsibility of the social service department is to the patients, but in many departments there is a distinct teaching function as well. There is an increasing conviction in the minds of leaders in hospital social work, that the highest quality of social service can be attained only when the medical, nursing and administrative services are fully appreciative of the social implications of sickness.

In the previous article we deprecated the assumption that all social interest in the patients should be relegated solely to the social service department. As evidence of opposition to this, we find developing in several departments another important function—that of teaching medical students and pupil nurses through case methods, the social significance of disease and the principle that the patient's medical condition, no matter how serious, is incidental to a broader social situation, rather than the social incidental to the medical condition.

Quality of Personnel Important

It is obvious that the success of a social service department is determined almost entirely by the quality of the personnel. Minimum standards for personnel in a social service department should demand that the chief of the service and the professional staff should be eligible to active membership in the American Association of Hospital Social Workers. The active membership requirements, as given in the by-laws of the association, are as follows:

"Any person may be admitted to active membership in the association who: (a) Has gradu-

ated from an approved school of social work as hereinafter specified: (1) Has taken a full course in medical or psychiatric social work and has had one year's experience in the practice of the same; (2) Has taken a full course in any other type of social work and has had eighteen months' experience in the practice of the same. (b) Has graduated from a registered training school for nurses and has had in addition eighteen months' experience in the practice of medical or psychiatric social work. (c) Has had at the time of application at least two years of case work experience in the practice of medical or psychiatric social work."

These standards should be equally true for medical social workers delegated to administrative functions, with whom we are purposely not concerning ourselves in this discussion.

Relating the Work to Size of Staff

Given an adequately trained staff with personalities suitable for clinical social service, we have still the problem of the relationship of the bulk of work to the size of the staff. This question, so far as we know, has not been adequately answered in any hospital of considerable size. Several hospitals of 300 to 500 beds, with large out-patient departments, have staffs of ten to twenty social workers, but none of them believes that the work is thus being satisfactorily covered.

If one were to study this question one would necessarily take into account the type of hospital, its special function, the economic groups admitted as patients, the capacity of the administrative, medical and nursing groups to recognize and attend to the personal and social problems involved in their care of the patients, and the resources of the community from which the hospital's patients come. We maintain that if all these factors are superlative, it would still not be suitable to reduce the social service department beyond the limit of one well trained medical social worker, who should be prepared to bring to the work clear-sighted social judgment, knowledge of community social agencies and of legislation governing social and health problems of the sick and dependent, and a resourceful capacity for counsel on personal problems and on the social policy of the hospital. But this is not the millennium. Medical and nursing staffs of the hospitals of today are not and cannot be free or adequately trained to carry all the many and complicated social problems of the patients whose lives they may save.

We have had the problems not only of finding the unit needing service, but the more involved problem of integrating the social work with the

medical service. In several departments it has been considered wise to let the department grow only so fast as the medical staff demanded increase. No social service can be called vital until it has secured the backing of at least some of the leaders of the medical staff. It has been argued that the vitality of the social service was dependent on the degree of correlation of the medical and social treatment and that therefore, the demand for the supplementary social service must come from the physicians.

There are others who insist that the social responsibility for the patients rests primarily with the administration, and that the impetus for the extension of social service should come from this source. We maintain that this problem rests with both these groups and that, given the opportunity, it is for the social worker so thoroughly to demonstrate her usefulness that there will be no question of backing for the growth of the department.

The question of organization of hospital social service is in part determined by the complexity and size of the medical institution in which it exists. In the small, simply organized hospital, the social service may be carried on as a part-time function, or in combination with other responsibilities, such as administrative assistant, social director of nurses or librarian. This subject needs special consideration and presentation with which we hope to deal later. We are concerned now especially with the more complicated hospital where special skill is represented in a variety of medical services, each in charge of experts. In such an institution the social worker should also be an expert in her field.

Cooperation Is Essential

Sound principles of organization demand that the personnel of a social service department should be brought into harmonious and systematic relationship with the personnel of all other parts of the hospital with which the department's interests are concerned; that lines of authority shall be clear, but not so rigid that they interfere with the free play of those human relationships that keep the spark of vitality in the organization. We must think of organization not as an end in itself, but as a method by which the members of the hospital personnel are enabled more easily to bring their special gifts of skill and personality to the service of the patients.

The story of the organization of social service in hospitals during the past twenty years is most extraordinary. The most remarkable thing about it is that hospital social service has survived so many obviously faulty methods of organization.

The clear focus on the patient and the recognition by those in authority that this interest in the patient was genuine and was needed, have made possible the gradual evolution of hospital social service into a recognized, integral part of the hospital.

Let us see what some of these various types of organization are and let us discuss some of their strengths and weaknesses.

During the demonstration period, hospital social service has been developed under a group of people who are interested enough in establishing a social service department to finance the project and stand back of it. (See Chart 1). While the social worker is in every instance subject to some, at least, of the hospital's rules and policies, this type of organization cannot truly be called organization since it is not in a real sense a part of the hospital. It is usually weak in its internal relationships, although the community relationships may be strong. Another possible weakness is the fact that the committee and the worker herself do not think of the service as part of the hospital. The workers do not identify themselves with the family affairs of the hospital, and therefore social service does not identify itself with the hospital to the extent of sharing its burdens as well as its traditions and privileges.

This type of organization presupposes a group of people vitally interested in the social service department, which is a strength. Because the

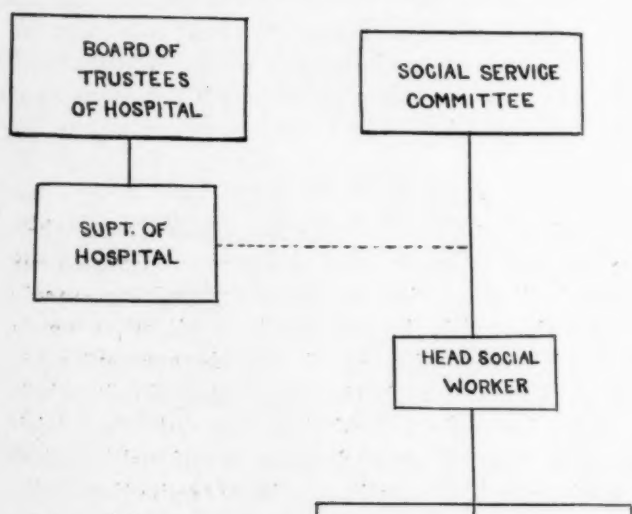


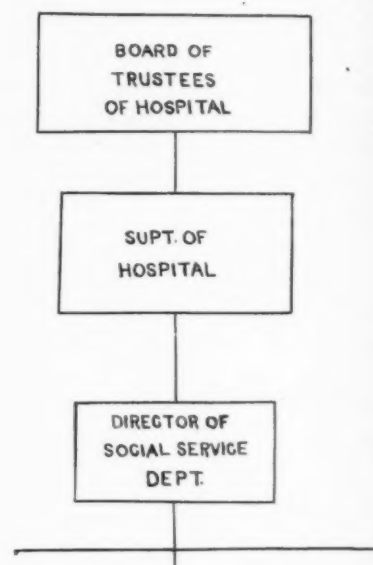
Chart 1. Early or pioneer type of organization of social service in hospitals. Funds and supervision in hands of social service committee, self-appointed or representative of an outside agency.

finances are raised by a special group, the work is usually freer to develop than if the budget were part of the hospital's budget and had to justify itself, along with the cost of fuel and supplies for the institution. This, we believe, should never be considered the ultimate form of organization, al-

though its existence during a period of demonstration where demonstration is truly needed, may be justified. The committee should include some representative of the hospital authority, as well as representatives of its medical staff.

Another early type was the organization of the

Chart 2. Social service as integral part of hospital organization, with the director of the department responsible to the superintendent. No advisory committee.



service under the training school for nurses. This type tended toward the weakness of confusion of function and is now practically abandoned. Sound organization demands that each unit of service be complete and distinct as to responsibility and function, while allowing for close correlation with the other units and free play between them. Hospital social service, as we understand it, is intimately related to medicine, just as hospital nursing is, but the two are not identical and should not be confused.

Possibilities for unhappy confusion of authority are seen, sometimes in the departments where the financial support does not come from the trustees or from a small committee vitally interested in the service, but from the community chest. Such a plan is acceptable only when the responsibility for policies, personnel and control is vested in the hospital trustees or in a joint group intimately familiar with the service, to whom the trustees have delegated authority for supervision. Authority over the department should never be delegated to the community chest, although the chest may offer to furnish funds for the demonstration period discussed above.

Provided that the lines of authority lead clearly to the trustees of the hospital, it is possible for a community chest to help in raising standards by agreeing to grant funds on the condition that high quality of personnel and service is maintained by the social service department. So far as we know at present, the tests applied are not very discrim-

inating. The formulation of a statement of accepted standards by the American Association of Hospital Social Workers would help in this matter. On general principles, it would seem wise for no hospital to relate itself to a community chest that is not an adjunct of a strong community council of social and health agencies or of a hospital council. This is even more true in situations where all the hospital funds are secured through the community chest. In this latter form, there is less danger of a division of authority, although it brings in other problems of limitation.

Chart II presents the form of organization in which the social service department is integrated in the hospital but has no advisory committee. The strength of this form is the acceptance of social service into the hospital family, where it becomes as truly a part of the service as the nursing or dietary or other supplementary functions. The lack of an advisory group of people particularly interested in the department and promoting its development, would be seriously missed by a social worker who had been associated with the type of organization seen in Chart 30.

What A. H. A. Advises

This form was advocated by the American Hospital Association committee that made a survey of hospital social work in 1920. The vertical lines show authority; the horizontal line, the advisory relationship. The committee, as outlined by the report, advised the appointment of "representatives of the trustees; the medical staff; professional social workers of standing in the community; nonprofessional laymen or women, with experience or connection with social work or community problems; the superintendent of the institution; the superintendent of the training school; the head worker of the social service department and ex officio member of the committee.

"This list is intended to be suggestive for the usual hospital organization. Under other circumstances, as for instance a social service department connected with a university, the advisory elements that should be brought together will readily suggest themselves."

Assuming the appointment of genuinely interested people who are able to work together, the strength of this organization seems to us obvious. The relationships of the social service department are many and complex. Meetings of such a group, bringing several different points of view, hold the possibility of fine creative discussion. The function of this committee should be so to familiarize itself with the department's activities and problems that it can helpfully advise the workers and make recommendations to

the trustees on questions of personnel, policies, community relationships and development.

Adequate consideration of organization should include the reference of patients, methods of control of intake in proportion to staff, the methods of selection of patients most suitable for social service and recording and financing, for all these factors in their acts and interrelation are problems of organization. But adequate discussion of all these matters cannot be undertaken here.

Is the service understood by those who should be concerned and are measures of its scope and extent applied? Are the activities suitably (if not logically) distributed? Are the right persons fitted into the right places within the personnel? Are the lines of responsibility definite and organic? Is there any unnecessary overlapping and

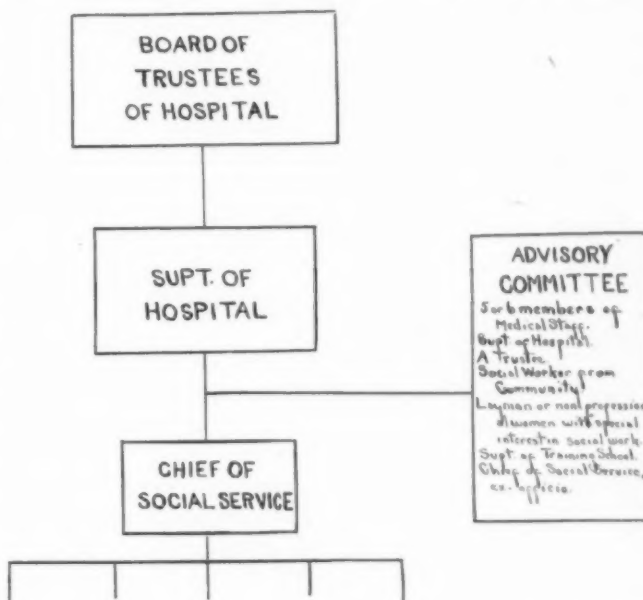


Chart 3. Form of organization recommended by the American Hospital Association in the report of the committee making a survey of hospital social service. Bulletin No. 24, 1920.

friction in the parts of the organization? Finally, are we making progress toward the accomplishment of the purposes of hospital social service—a more satisfactory form of service to the patient?

This discussion has touched only part of the internal problems of organization with which the hospital social worker is concerned. There are for her, also, all the vitally important relationships to social agencies and other social workers in the community with which she is in daily contact. She is the hospital representative primarily responsible for working out the most fruitful interplay of services for the individual patients, realizing that whenever questions of hospital policy arise responsibility for any change or re-interpretation must revert to the administrative officer.

Editorials

"Let's Build a Hospital!"

HOSPITAL building projects originate in a variety of ways. Sometimes, after a careful study of community health needs, and a later businesslike survey of present and future financial requirements to meet this need, the hospital is carefully and painstakingly planned and finally constructed. Alas! this is not always the course of action pursued. Just as often a less cautious and conservative plan is followed.

Sometimes a member of the family of the town's most wealthy and distinguished resident becomes ill. No medical aid being immediately available, this man decides to build a hospital, in order to prevent the repetition of such a distressing circumstance.

Again, a practitioner of medicine may desire to create a more convenient place in which to treat his patients than is provided in the average home. (This may be classed, in a measure, as a business urge, as compared with that with an emotional basis, mentioned above).

Town pride often points to the need of a hospital plant, just as it does to the need of other utilitarian and humanitarian possessions that near-by communities may own. Again, the urge may have a fraternal or religious aspect. Or a wealthy resident of the community may die and bequeath a sum of money to the town, with instructions that it be spent for the construction of a hospital. Such a community may later find itself in possession of a liability rather than an asset, unless endowments to assist in maintenance are soon forthcoming.

Too often the question of the need for a hospital and the ability to support it is decided without a careful inquiry into the cost of construction and maintenance, or even as to the medical justification of an effort of such magnitude. A factory is never constructed until its promoters learn as to the need for the article to be manufactured, and as to the probability of a profit accruing from the plant's operation.

The building of a hospital differs in no great respect from the construction of a building to house a commercial enterprise. It is a matter of supply and demand. Since the product of the hospital is less easy to evaluate, however, a survey of the local field—even more careful than that preceding the launching of a business venture—is necessary. Statistics as to present population and

average morbidity; an estimate of these conditions a decade hence; the size of the institution necessary to meet the need; the probable income from private rooms, and other possible sources of revenue, represent but the most elementary type of information. It is not usual for a community to be able to collect these facts without outside aid from those trained to evaluate such data.

To make haste slowly; to refuse to be stampeded into campaigning for hospital funds; to seek advice from every available source; to build largely for utilitarian, not artistic, purposes; to look long before leaping, financially, are all good rules to observe before following the advice of him who exclaims: "Let's build a hospital!"

Is the Out-Patient Department a Stepchild?

HEALTH is the slogan of our generation—health for children, health in industry, health for all. And surely in the universal search for health the out-patient department has an important place and a function to perform, for the trend of medical practice is away from individualistic toward organized practice.

There is an undoubted awakening of scientific interest in the out-patient clinic as a public health institution and governing authorities of hospitals are realizing more and more that the out-patient department is the place where many patients are seen during the most hopeful stage of their condition, and at a time when prompt treatment holds out the greatest hope for cure. It is, therefore, deserving of as much attention as the wards for whose special benefit the hospital, until recently, believed itself to exist.

The problem most frequently uppermost in the minds of those responsible for out-patient service is that of obtaining and maintaining an adequate staff, and in his article on page 59 of this issue, Dr. Brennemann speaks with enthusiasm of the genuine interest and the educational value that work in this department offers. Here, he believes, the young physician has an opportunity to acquire a high degree of clinical efficiency, for nowhere else can he see so many patients in so responsible a capacity. A staff connection in terms of out-patient service should be the first medium in higher education in medicine and a stepping stone to higher responsibility.

If those patients whose illnesses indicate the necessity for care in the hospital as well as in the out-patient department are to have continuity of medical service, there must be a close functional

relationship between the personnel of both departments. The medical staff of the hospital and the medical staff of the out-patient department are not two separate entities. The services of these men must be linked, and the ward surgeon must know the problems of the clinic and the clinician must have an opportunity to contact with the problems of the ward.

Thoughtful consideration should be given to Dr. Brennemann's protest against the too prevalent idea that service in the out-patient department is a purgatory through which the physician must pass in order to reach that more desirable place—the ward service. If the out-patient department is to assume its rightful place in hospital service we must cease to regard it as the stepchild of the hospital, for, allowing prophecy to take wing for a moment, we might predict that a time is coming when the out-patient department of the well regulated hospital will overshadow and outgrow in importance the service in the wards.

An Injustice to the Hospital

GRIEF occasioned by the loss of loved ones causes a definite mental reaction in the bereft. We often observe, on their part, a shrinking from the stern realities of workaday life; an unnatural disregard for costs, where frugality was to be found; an inability or an unwillingness to make decisions. Indeed, the visit to the undertaker's parlors, at which time the burial details are arranged, seems to be an ordeal to be quickly terminated at any cost.

Whether this psychologic reaction to grief is responsible for a lavish and often foolish expenditure of money for funeral expenses, or whether this should be attributed to a rush of fond remembrances of the departed, is not pertinent to the question at hand. Certainly, it is not a necessary manifestation of true grief and respect for the dead to spend every farthing of a death claim for a funeral.

Nevertheless the unvarnished fact remains that in 15,100 instances studied by the Advisory Committee on Burial Survey of New York, 62.1 per cent of the money left by the deceased was spent for burial. This study reveals that in this series the undertaker's bill ranged from a low average of \$233 in one state, to a high average of \$493 in another. It was also noted that funeral expenses were relatively higher amongst persons of the lower economic class than in the case of those whose efforts had been more productive financially.

If undertakers, as a class, take undue advantage of the peculiar mental state of their clients, by cunningly encouraging the extravagant expenditure of money for funerals in order that they may profit thereby, they are approaching too closely the borderline of sound ethics and fair dealing. No such generalization, however, can be made with fairness in regard to the many embalmers who are ethical, fair and considerate of their patrons.

But of what concern is all this to the hospital? There are surely bills other than those covering funeral expenses, which can be classed as legitimate claims against the revenue accruing from a death claim. Should the hospital lightly waive its claim for reimbursement for the care of the patient because the family chooses to expend money extravagantly for mortuary expenses? Should not the priority of claim, upon which the physician and the undertaker insist, also include the obligation to the hospital as well? Wisely and justly drawn compensation laws should protect the hospital in this respect, if the patient lose his life as a result of an industrial accident.

In comparison to the magnitude of the undertaker's average bill, the hospital's claim often fades into insignificance. Would it not be right and equitable for the superintendent to refuse to allow insurance papers to be executed by the hospital's physicians until he is assured—even when the amount of the policy is moderate—that his institution will receive a fair percentage of this sum?

It certainly is unfair—indeed, it seems to approach the realm of dishonest dealing—for an exorbitant and unreasonable amount of money to be turned over to the undertaker, while the community is asked to bear the expense of treating the patient before death. Insurance for hospital expenses is just as necessary, even if not as pressing, as insurance for burial charges.

Talking It Over

“**A**PRILLE with his shoures soote” is upon us. Once the second month, now demoted to the fourth, it saw Peary's polar conquest, the tragic loss of the Titanic and the birth of the courageous Albert, King of the Belgae, of Jefferson who created the empire of the Mississippi Valley but didn't believe in kings, and of that captain of the men of health, Baron Joseph Lister—a good month for the planting of seeds that neighbors may have fat chickens. The towel-beturbaned housewife, a whirlwind of cleanliness, now makes uninhabitable the home; males should hide their fishing poles and depart for an important business conference in a distant city where golf courses are coming into blossom. About now the fish should be biting pretty well and it might be a good idea

to have the screening overhauled and the lawn fertilized. Valedictory and other platitudinous inflictions begin to germinate this month.

* * *

APRIL showers mean rain, and rain means vegetation, and vegetation means growth, and growth should be the goal of all of us. While January is the month of many official inventories, April should be the unofficial month of stock taking as well as housecleaning. We should be stimulated by the cleansing rain that washes away the accumulated *débris* of winter and starts the grass and buds, and we should cleanse our own institutions both physically and mentally, wash away the accumulated deadwood and *débris*, leaving room for proper growth of new ideas and ideals. There should be a thorough overhauling of the buildings, equipment and methods of administration and of our own mental attitude. The fruits of spring housecleaning should be indeed inspirational to our coworkers.

* * *

ALSO this is the only month setting aside a day for fools. None is reserved for wise men, perhaps because so few could qualify. After all, a fool is a person who doesn't agree with us and may he not be nearer to the normal (the average) than the so-called wise? May not true wisdom lie in being natural? If so, our directory of fools perchance must be recast.

* * *

ONE more thing about April. It is believed that Shakespeare was born in this month but there is no certainty as to the day. Church records show that he was baptized on the twenty-sixth and that he died on the twenty-third. It is presumed that he was born. Moral: have your parents register your birth.

* * *

THERE has been a general strengthening of state hospital associations during the past year and it is gratifying to note that the attendance at state meetings this year will probably be greater than ever before. Also there is an inclination toward consolidations of states into sections and this, too, is a step in the right direction. Some day it is hoped an equitable plan will be worked out whereby all of the smaller organizations will be part of the national organization, but great care must be taken that "state rights" are not interfered with or their values curtailed.

Most of the meetings this year come in March, April and May and, combined, nineteen states will be in session. The state meeting should be the feeder for the national meeting and it will be if the national body will let it.

* * *

AMONG the cardinal virtues should be listed promptness. Honesty and loyalty, industry and clean living are all very well, but they are not to be compared with punctuality. If the appointment is for nine o'clock it is a sacred duty for those concerned to be there. Discussions often arise at superintendents' meetings regarding the tardy surgeon at the operating room. Revocation of his license is too mild a punishment, because a man so careless and inconsiderate must cause untold suffering to patients, his own or others, who are held up by his selfishness in being late. The evil, however, is not con-

fined to surgeons or hospitals. We are living in an age when time is actually money, and when someone is kept waiting long after the appointed hour the tardy person is, in effect, a robber who has held up a man and stolen valuable minutes from his life.

* * *

LETTER writing, after all, should be considered one of the fine arts. There should be a course of instruction in this science and it might well follow a course of instruction in courtesy. It is almost inconceivable that a man in any sort of business would write a discourteous letter, yet it occurs sometimes in places where it is least expected. When a man tells you with much heaving of his diaphragm that he has just sent a "hot letter" you may be sure you are wasting your time talking with a fool. It is childish and cowardly, and furthermore the recipient of the discourteous letter usually treats it with ridicule. Even good letters are apt to be ambiguous, poor ones are bound to be.

* * *

SO MUCH has been said regarding high costs of this and that that perhaps many of us are a trifle "fed up" on the subject. But here is an additional thought: What is the proper price to pay for health and life itself? Very glib are those who talk about high costs but never do they place a definite figure on their own life or the health of their families. If you try to pin them down they will get behind annoyed looks, wave you away as unbusinesslike, and curtly tell you that your remarks are beside the point. Yet the truth is they are too much to the point to suit those who make general unfounded statements and they know it.

* * *

A Child in the arms of its mother:

A smile of gratitude:

A handclasp of friendship:

Sun on the dew:

Moon on the water:

A tree in blossom:

How beautiful!

* * *

OFTEN the doctor's opposition to nurse training is not well founded because he has no real appreciation of the work that is being done. Would it not be a good idea—or at least a fair idea—to have medical students and premedical students spend their summers as student nurses? When they become staff members and the work of nursing is discussed they will at least understand the problems under discussion.

* * *

THE negro, our great economic and social problem, constituted nearly 20 per cent of our population in 1790 as against less than 10 per cent today, despite the fact that he has increased from about three-quarters of a million to nearly ten and a half millions. The increase rate in the white population so exceeds that of the colored population that statisticians estimate that by A. D. 2000, less than 8 per cent of the total will be negroes. There has been a marked improvement in the colored death rate and a decrease in the birth rate, especially in the North. Even in the South there is little excess of births over deaths. The longevity of the two races has apparently increased at about equal rates.

The Modern Hospital Reading Course: Lesson XVI

Hospital Case Records and Professional Standing Orders

By C. W. MUNGER, M.D.

Superintendent, Grasslands Hospital, Valhalla, N. Y.

"A MEDICAL examination is as well not done if it be not carefully, accurately, promptly and permanently recorded." Such a statement sounds radical, but it probably approximates the opinions of persons who have made a careful study of medical records in hospitals.

Certain physicians have kept records of their cases from time immemorial. Many hospitals have files of excellent and complete information concerning patients treated decades ago. The management and the staffs of those hospitals, without any pressure from outside agencies, had recognized the value of complete records. It was in these institutions that the pioneer work in medical recording was done, and it was their experience that formed the basis for our present day record systems.

In the majority of hospitals, however, the case records kept prior to about 1916 were scarcely worth preserving. It was the hospital standardization program of the American College of Surgeons¹ that first focused the attention of all hospitals upon the importance of the preparation and preservation of detailed information concerning their work with the sick. Previous to the inauguration of this program, the efficiency of the physicians and their medical service in the hospital could be gauged by the type of medical records kept. Records are still a measuring rod of medical efficiency in hospitals, but to a lesser degree than formerly. This is because all institutions of any importance have striven to comply with the requirements of the American College of Surgeons, and in some hospitals the administration has, in doing so, kept records up to a higher standard than their medical staffs were prepared to appreciate or utilize.

This is the only fault, in my opinion, in this tremendously helpful work. The fact is, that failure to gain approval by the college falls much more heavily upon the hospital than upon the individual physicians on its staff. If the program could have exerted more pressure directly upon the staff physician, the result would have been even better.

Why have our leading physicians and hospital administrators considered medical records important? What is the value of records from the points of view of the patient, the physician, the hospital and humanity in general? Answers to these questions were more necessary twenty years ago than now. In spite of the general recognition of the value of properly managed case record systems, it seems wise to outline for the student, the principal points.

Medical Value of Records

The development of specialization in medicine, with, in hospital practice, as many as half a dozen or more physicians consulting on the same case, has entirely done away with the old idea that the memory of the attending physician was the only record necessary.

The greatest use for medical records is while the patient is undergoing treatment in the hospital. With every procedure recorded, a complete picture of the patient's case is available to attending, consultant, intern and nurse alike. Faulty memories will not jeopardize the patient's welfare. Prolonged recitation of history and symptoms by one physician to another is no longer necessary. The record is there, and if it is a good one, it tells a complete story of the case from admission to discharge.

Medical records are extremely useful in connection with subsequent admission of the patient to the same hospital. The former record often contains information much more helpful to the physician than any knowledge which the patient has concerning his past condition. It is the custom also if a patient has been previously in some other hospital, for the hospital to which he is later admitted to apply to the former for a transcript of his record.

Without proper case records there can be no compilation of valuable medical statistics for hospitals or groups of hospitals. Monthly and annual compilation of information obtainable from medical records is an excellent check upon the efficiency of the hospital as a whole, and of the individual physicians treating patients.

The prime purpose of the record is, of course, to benefit the patient medically. The patient, however, is safeguarded legally in many instances. For example, subpoena of the record enables any court to obtain a true statement concerning the patient's care and treatment in connection with insurance claims, employees' liability claims, suits for damages and malpractice.

The case record is of tremendous importance in safeguarding the hospital against persons who, through ignorance or design, may bring unjust legal suits against it. The doctor, likewise, is safeguarded in unjust suits or accusations on the part of the patient or anyone else.^{2,3}

Educational Value

Teaching of medicine is expedited through the use of medical records, current and past. There is no more effective teaching method than the citing of cases illustrating the point under consideration. Record keeping is instructive to the attending physician and especially to the hospital intern, for in order to write a proper record the doctor must think the case through sufficiently to impress it upon his memory, and thus adds to his store of experience. The part which the nurse plays in record keeping teaches her the importance of accuracy and clear thinking in connection with her work.

The record of the patient's past illnesses often means a saving in money to him, because it obviates the repetition of numerous expensive examinations, tests and other procedures. The hospital and the physician undoubtedly profit because of lessened danger from damage suits.

The modern methods of medical research depend primarily upon records. Except in the case of a few startling and accidental discoveries, most of the advancement in medicine has come through painstaking study of past experiences in connection with the disease under consideration. It is frequently possible to prove the truth or the fallacy of medical hypotheses through compilation of the information contained in past records. This can best be done through the medium of hospital case records.

It might be well to interpolate here the statement that in most hospitals the preparation of medical records is superior to the utilization which is made of the records after they have been prepared. The physician or the hospital failing to take advantage of the knowledge obtainable from these records is missing a golden opportunity, not only to improve individual results, but to make some real contribution to knowledge.

What is a patient's record? What does it include and how is the record made? Records re-

garding patients actually in the hospital are ordinarily kept adjacent to the ward or room during the patient's stay, and are then permanently filed in the medical record department. Records of out-patients are kept in a file convenient to the clinics. These records are brief but complete, and are available, when the patients call, for the physician to use to record facts concerning current treatment. This article will concern itself with the in-patient record. The out-patient department will be considered in another article.

The bedside record includes the following:

1. Notes by physicians regarding patient's condition upon admission; progress notes.
2. Records of special diagnostic tests.
3. Records of special treatments.
4. Records of important nursing procedures and the nurse's reports regarding the patient's daily condition.
5. Notes regarding the patient's diet.
6. Special permits and authorizations.

In addition to the above, there are occasionally certain other records which become a part of the patient's chart.

The physician's clinical notes contain a complete and detailed medical history and a physical examination done soon after admission. Preceding these, many hospitals have also an admitting room note recorded by the physician receiving new patients. The admitting room physician makes a tentative diagnosis. The physicians in charge of the patient on the ward, after they have given the case a thorough preliminary study, record a provisional diagnosis or diagnoses. The attending or intern or both, make progress notes from day to day. A final note summing up the condition of the patient is made by one of these after the discharge or death of the patient, and at the end of this note the final diagnosis is recorded.

Method of Recording Varies

The mechanics of recording physicians' clinical notes varies in different hospitals. It is seldom that the attending physician can devote sufficient time to write the record in longhand. The more usual plan is for the intern to make a history and physical examination, these notes to be checked at the bedside by the attending on his first visit, and a final draft recorded as soon as possible by the intern. Even the intern, if he is on a busy service, finds all of this paper work onerous, and the hospital can expedite its record keeping if it provides a sufficient number of stenographers capable of taking medical dictation and transcribing these clinical notes on the typewriter. Dictaphones are used in some institutions, but the writer does not consider them especially success-

ful. Stenographic service in recording surgical operations makes complete notes possible.

It is important that the medical record be complete, but not so brief as to omit facts that may later be of importance. It is customary for hospitals to devise skeleton forms for history taking in the various medical divisions. As a general custom, the plan of developing complicated blank forms for the intern to fill out is not recommended. It is applicable in certain specialties such as obstetrics, but usually the plan is unwieldy. It is sometimes convenient to have a skeleton outline of history and physical examination printed in small type in the upper righthand corner of the history sheet. This serves as a guide for new interns or for clinical clerks who are performing these services.

How Diagnoses Should Be Written

When the final diagnosis has been determined at the end of the patient's stay, it is necessary that this diagnosis be so worded and numbered as to conform to the diagnosis nomenclature adopted by the hospital.

The enforcement of frequent writing of progress notes is always a problem in hospitals and only constant attention by the resident and attending physicians can guarantee that the clinical record will tell an unabridged story of the case.

There are numerous methods of recording physicians' orders. Probably the most common is the use of a doctors' order book into which the date is inserted each day, orders written that day following the date. According to this plan, the nurse then copies these orders on an "order sheet" which is kept on the patient's chart. For legal purposes, the order books with original signatures must be preserved. This "order sheet" indicates the date of institution of an order, with a space for the date of cancellation.

Still other hospitals have the doctors write their orders directly upon the "order sheet," thus preserving the original signature with the patient's record. This is a safe method from the point of view of future legal complications, but adds greatly to the work of the nurse who must look through every chart several times a day to see if orders have been written.

Still another plan requires writing of the order direct upon the "order sheet," which, however, is not placed upon the patient's chart, but is kept in a separate looseleaf binder until the patient's discharge, when it is attached to the chart.

The principal special diagnostic tests are those done by the laboratory, the x-ray, electrocardiograph and metabolism departments. Some institutions use a separate sheet for each examina-

tion of the above nature. The result of the test is recorded on this sheet, and it is sent to the ward and attached to the chart as soon as possible. This plan is satisfactory for records of x-ray examinations, but is difficult for laboratory work. The many laboratory tests required in modern medicine add greatly to the bulk of the chart if separate sheets are used for each test. It is usually better to use laboratory sheets on the charts with multiple spaces for recording each of the commoner tests.

A clerk or other laboratory employee makes the rounds of the wards daily, recording on the charts results of tests. It is of considerable importance that the final recording of any special test be done by a person familiar with the work of that department. Dependence upon the ward nurses for this copying service is likely to lead to inaccuracy.

It is also necessary to work out arrangements for reporting electrocardiographic examinations, metabolism tests and other diagnostic procedures. Needless to say, all of these special departments must keep complete record systems on their own account, of all work done by them.

With regard to the recording of special treatments, similar conditions pertain to those existing with diagnostic tests. Prompt and accurate recording of x-ray and physiotherapy treatments and occupational therapy work is essential.

An important part of the duties of the ward nurses is the careful and accurate recording of temperature, pulse and respiration of patients on the special sheets that are invariably provided for this purpose. The head nurse or her assistant is also responsible for entering daily notes concerning the appearance, actions, symptoms, complaints and general conditions of patients under her care. Records of this nature are made by both day and night nurses. The nurse also records the administration of all medicines, and a record is also kept of excreta and special nursing procedures, such as enemas and catheterizations.

Dietetic Records

In cases not presenting special dietary problems, it is customary for the nurse to note such matters as abnormalities of appetite and refusal of food. In diabetes, nephritis and the many other conditions requiring specially prepared or calculated diets, it is desirable that a special diet sheet be inserted in the chart with daily notes from the dietary department.

The development of record keeping in the hospital has necessitated the employment of a trained person, variously called "medical record clerk," "historian," "statistician." This position requires a person with considerable education and general

ability, a clear understanding of medical terms, ideals in medical record keeping and a grasp of the significance of the various professional procedures used in the treatment of patients in hospitals. A thorough knowledge of filing and statistics is also essential.

Practical courses have, from time to time, been offered by hospitals to persons with sufficient preliminary preparation to give promise of success in this specialized work. Such representative institutions as Bellevue and Presbyterian Hospitals, New York, Massachusetts General Hospital, Boston, and Mount Sinai Hospital, Cleveland, have been of great assistance to the hospital field in this connection. D. M. Trotter has worked out a successful course for historians at the Blodgett Memorial Hospital, Grand Rapids, Mich. The American College of Surgeons has offered valuable assistance and advice in record room work.

A successful hospital record system depends mainly upon two factors, namely, careful attention to records by attending and resident doctors and a well trained and conscientious record room staff. Proper transcription of clinical notes by stenographers in the record room is essential to the usefulness of the chart on the ward. Successful use of the chart after the discharge of the patient depends entirely upon record room efficiency.

Record Room Routine

Upon discharge of the patient and completion of his record by the physicians, which latter should include signing of the record either by the attending physician or the chief resident, the chart is carefully studied by the record room staff. Rearrangement of pages is usually necessary so as to maintain a proper sequence of the various types of records in all charts. The historian also makes an extra check of the record following that of the resident physician, to make

certain that all reports are recorded and that the record truthfully tells a full story of the case.

Many details of the record are then analyzed and data entered on trial sheets from which monthly and annual reports are compiled. Soon after the end of the month the record department is thus able to issue a monthly report of medical performance, which provides sufficient detail to give all concerned a clear picture of the medical accomplishments or shortcomings of the hospital. This report contains analyses of civil data, analyses of results, including details regarding patients whose condition is unimproved or who have died, information concerning consultations, transfers and releases. The reader is referred to excellent reports on this subject obtainable from the American College of Surgeons.⁴

The record department is also able to compile statistics of value to the hospital and its staff concerning results of treatment obtained by individual physicians. Such records kept over a long period are of assistance in judging relative ability of the staff members, and should be considered when reappointments or promotions are to be made.

The record is then filed. The more approved systems include alphabetical cross filing of the record according to the name of the patient, cross filing according to principal diagnosis, according to secondary diagnoses, according to surgical procedures, and sometimes according to other special procedures, such as electrocardiograph and x-ray therapy.

Cross filing of medical records requires the use of the same nomenclature by all persons writing diagnoses in the hospital. The hospital must devise its own nomenclature or use one of the standard published ones. The nomenclatures in use at Bellevue Hospital, New York, and Massachusetts General Hospital, Boston, have been widely used by other hospitals. Dr. T. R. Ponton, form-

Review Work

1. Why are hospital records of medical value to the patient?
2. Why are hospital records of legal value to the patient?
3. Why is it necessary to cross-file medical records according to diagnoses?
4. What are the principal divisions of a completed hospital record?
5. Name three methods of recording and preserving doctors' orders.

6. Make a job analysis for the chief medical record clerk of a teaching hospital of 500 beds. What other employees would be needed in that department?
7. Name five advantages accruing to the patient through the use of printed professional standing orders.
8. Name five advantages accruing to the hospital through the use of printed professional standing orders.



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erly superintendent of Hollywood Hospital, Hollywood, Calif., has recently produced a nomenclature and there are many others of varying completeness and merit.

The record itself is, in some institutions, filed in a separate folder; in others, it is bound in a permanent volume with other records. In my opinion, single unit filing of charts is preferable, since it permits assembling of records into groups according to any classification or problem. Records bound into permanent volumes necessitate frequent handling of large volumes in order to examine possibly one or two records pertaining to the subject in question which they may contain.

Charts may be filed in stacks such as are used in libraries, although fireproof and dustproof metal cabinets are to be preferred. Record rooms should be so designed as to accommodate an accumulation of the records of four or five years. Additional fireproof space should be provided in the basement or elsewhere for the older records, which should, however, be accessible. In nonfireproof buildings all record room files should be housed in fireproof vaults.

Detailed description of the printed forms required for medical record work is being purposely avoided. These forms should be a subject for special study by the student.^{5, 6, 7}

How the Historian Can Help

As previously mentioned, much of this detailed record work is in vain unless the records are actually used. Where it is possible, the person in charge of records should be relieved of enough of the routine work to be free to study and use the records, in addition to the issuance of monthly and annual reports. The historian should be available for compilation from the records of special information required by the staff or by the management of the hospital. She should be encouraged to study special problems; she should be called upon to assist in the preparation of scientific articles, and to assemble groups of patients' records for various uses; she should be able to cooperate in connection with any medical research that is in progress, and she should prepare such graphic charts as will give clearer pictures of various phases of the medical work.

The medical library is found in many institutions in connection with the record department or, as the latter might be called, the library of case records. The Treadwell Library of the Massachusetts General Hospital is a fine example of such a combination. The size of the library will, of course, depend upon available resources. It should certainly have a good collection of modern

textbooks of medicine with as many specialized volumes and monographs as are procurable. A considerable part of the annual budget for the library should be put into current medical journals. If comfortable reading rooms and good library service are available, the physicians will take advantage of them and the work of the institution will most certainly be favorably affected.

Professional Standing Orders

Efficient hospital administration and economy are impossible without thorough correlation of basic orders, customs and methods throughout the institution. Hospital practice is so detailed and complicated, and methods necessarily differ so greatly, that there can be no concerted effort unless the fundamentals of the medical work are outlined in printed form.

Printed editions of these customs or "Professional Standing Orders" have been issued by many hospitals, but unfortunately by fewer than the necessity indicates. In one instance, the three hospitals of a medium sized city were able to meet and formulate a single order book applicable to all three.⁷ This meant slight sacrifices by the individual institutions, but it has proved helpful, inasmuch as there was marked overlapping of medical staffs, and there had been confusion because of varying methods in the hospitals. Standardization of hospital orders beyond this seems inadvisable, at the present time. A set of standard orders that would fit all hospitals would have to sacrifice so much of its detail as to be practically useless. Differences in aim, type of work, location, and internal organization will always exist and will probably preclude complete correlation.

The preparation of a book of standing orders requires long and careful consideration by a group representing attending staff, resident staff, the administration, the nursing department, the special diagnostic, special therapeutic and the dietary departments. It is helpful to select standing order books of several good hospitals and use them as guides in the work.⁸ This task must of necessity cover quite a long period because the orders will need to be rewritten a number of times in order to satisfy all factions and avoid errors. Some of the logical divisions of a standing order book may be outlined as follows:

I. General orders, which pertain to patients on all services.

- a. Admission routine.
- b. Ward routine.
- c. Order book routine.
- d. Specimen routine.
- e. Nourishment routine.
- f. X-ray preparations routine.

His answer on milk

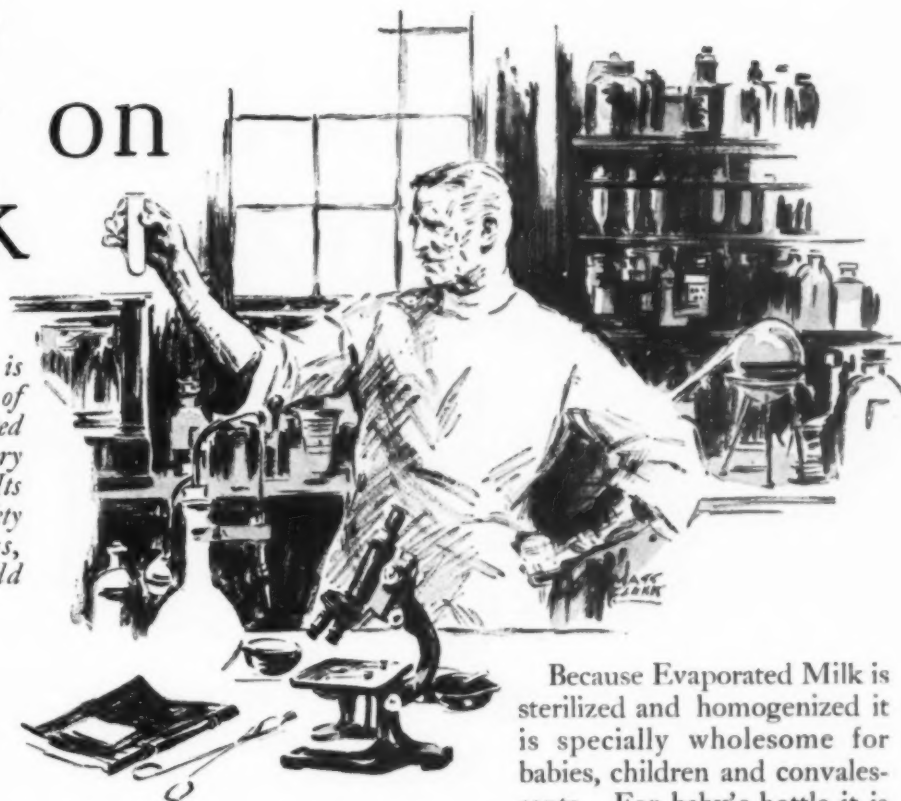
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II. Surgical orders.

- a. Preoperative routine.
- b. Operating room technique.
- c. Postoperative routine.

III. Care of transmissible diseases. These must be detailed and are essential whether or not the hospital maintains a communicable disease service.

IV. Obstetrical and nursery routine in detail.

V. Eye, ear, nose, and throat.

VI. Internal medicine. (Special subdivisions for the principal diseases.)

VII. Pediatrics.

VIII. Neuropsychiatry.

IX. Emergency room procedures.

X. Miscellaneous.

The book should be carefully indexed. It must be neither too brief nor too detailed, and should be written with such clarity as to be easily interpreted by doctors and nurses. The orders should be inclusive of routine duties of both physicians and nurses.

Booklet Should Be Studied

Such a booklet may be given out for study to new interns or residents and to new members of the staff, and may be thoroughly taught to student nurses in the training school. It is probable that revisions will need to be made about every two years in order to keep the hospital's methods up-to-date.

Medical records, medical libraries, and professional standing orders are of much importance and must be thoroughly understood by the administrator who hopes to be successful, for all of them are important stones in the foundation of the hospital's medical work. Their proper use will largely determine the efficiency with which patients are treated. Without such efficiency a hospital has little excuse for existence.

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Hospitals as Training Schools for Health

In the past years most of the members of the medical profession have devoted their efforts toward combating disease and aiding those whose health has broken down.

In a recent issue of *Hospital Social Service* appeared an article by Dr. H. E. Kleinschmidt, supervisor medical service, National Tuberculosis Association, New York, in which he expressed the belief that the hospitals will, sometime in the future, be regarded as a training school for health instead of a repair shop. The basis for this prediction, he states, is the general change in the trend of medical thought. In the past men devoted their efforts toward the cure of disease; at present they are learning preventive measures with which to combat disease. It follows that in the future the doctor's duty will be not so much to cure as to instruct his fellowman in the prevention of disease and the maintenance of health.

Nearly 50 per cent of the medical practice today is concerned with disease prevention and health promotion, according to Dr. Kleinschmidt, and this proportion will grow as new facts about prevention are brought to light.

Books Shorten Tedious Hours for Children

"When I enter the children's ward, I imagine the book cart to be a ship—a ship of mercy—piloted on a sea of homesickness, pain, loneliness," says Pauline E. Tartre, chief of extension work, Bangor Public Library, Bangor, Me. "These boys and girls whom I face are so many Crusoes stranded on an island, a bed. They have received help it is true for their bodies—the doctor and nurse in turn have administered to their needs—but what help have they received for their minds? The visiting hour is over, there is nothing to do but to wait and for what? For another night, another day, the day that is bringing them nearer home. The book wagon indeed becomes a ship of mercy at this time and is greeted with a cry of joy and relief. It is bringing its load of cheer that will shorten the tedious hours. The fairies, the Brownies, even the bloody Indians will soon carry the children far away from the sound of bells and the odor of ether and medicine."

Regarding Pensions for Hospital Officers

A doctor or a hospital officer is looked upon as one who is devoting his life to the welfare of his fellowmen and as such is not expected to worry about himself or his future. Thus when he begins to think of old age coming on, and of the days when he will no longer be able to support himself through his practice, he is apt to ask for some assurance that he will be cared for when these dark days arrive.

In a recent issue of the *Hospital Gazette* was an article on the "Superannuation Scheme for Nurses and Hospital Officers." It was pointed out here that experience had shown that in institutions where pensions were given, the hospital officers were more dependable, more sincere and worked more whole-heartedly than in the institutions where pensions were not given.

It seems logical that if a man can be assured of his future, he will more willingly settle down and attach himself to a certain institution. With the settling down process comes a certain liking for his surroundings, and with all this comes a deep interest in the development of the institution. Doesn't it look as though a pension offer might increase the efficiency of the staff?

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YOUR EVERYDAY PROBLEMS

A department devoted to the informal discussion of problems arising in the everyday life of the hospital superintendent.

[No attempt has been made to offer final conclusions relative to the questions considered in this department. THE MODERN HOSPITAL will gladly welcome further comment by its readers on any of these problems, or the presentation of other queries for discussion in later issues.—Editor.]

Is It Ethical for a Superintendent to Censure Pupil Nurses for Uncleanly Wards?

Recently a hospital superintendent in making rounds found that a certain ward in his institution had not been properly cleaned. The pupil nurse who happened to be on duty then, was openly censured by the superintendent for her failure to maintain the ward in a sanitary condition. The patients and attendants overheard this reprimand.

If there is one rule that hospital administrators have always been agreed upon, it is the inadvisability of censuring any one, high or low, in the presence of others. Orders can be given through channels and corrective measures instituted in the same way. It appears to have been exceedingly inadvisable for the superintendent, no matter how exasperated he might have been, to have censured the pupil nurse, although she may have been guilty of neglect of duty. The routing of orders from the superintendent to the pupil nurse is surely by way of the superintendent of nurses' office. No harm would have been done in this instance for the ward to remain uncleanly a little longer, in order that the rules of good administration could have been observed.

Nor is there any question in the mind of anyone but that the superintendent has the authority to express his disapproval of the acts of any other member of the hospital personnel. The question is one of good judgment rather than of the presence of authority. Much of the unpleasantness that arises in hospitals the country over, is due to thoughtless or unwise lack of observance of this fundamental principle. In this particular instance, the superintendent should certainly have communicated the results of his inspection to the superintendent of nurses, or if she were not at hand, to her assistant or even to a floor supervisor, and the correction of the defect would have followed as a natural result.

Should the Hospital Be Responsible for Providing Religious Attendance Upon Critically Ill Patients?

The hospital in its broadest sense should minister not only to the physical but to the spiritual side of sick persons. Some institutions, it is feared, are somewhat careless in regard to the latter duty, much to the distress of relatives as well as of the patient. In larger institutions, chaplains from various religious denominations

are often assigned to bring spiritual solace to those who are ill. In other institutions, ministers from the various denominations in the community visit the members of their congregation who become ill and who are admitted to the hospital.

However, many persons enter our hospitals who may be strangers in their communities or may not be affiliated with any particular church. It appears that the superintendent should take note of the fact that these patients might desire the spiritual comfort that follows the visit of a clergyman, but who are unable or perhaps unwilling, to ask that a clergyman be summoned. The superintendent, of course, must be more than careful to avoid any appearance of proselyting. Sometimes a tactful nurse or a social worker can secure information as to the patient's wishes, but unless somebody makes it his or her business to attend to the fulfillment of the patient's request to see a clergyman, valuable time may slip by and consciousness may be lost before the representative of the church arrives.

It matters not of what denomination or sect the patient may be a representative or whether he be affiliated with any. It is a fine thing for members of the clergy to take an active interest and part in the conduct of the community's hospital. Nor need such an interest in any way interfere with the progress of the scientific work of the hospital. Clergymen are always understanding and willing to leave the patient's presence when the doctor or nurse has work to do there. It is an important function which the hospital owes to the patient and his relatives to provide for the critically ill patient all possible scientific aid and spiritual comfort.

Who Is Responsible for the Records in a Fifty-Bed Hospital Without Interns?

Members of visiting staffs do not relish being held responsible for either the scientific accuracy or the completeness of patients' records. History writing is just as much the bane of the life of the successful practicing physician as it is of the hospital intern. With so much importance being now rightfully placed on the necessity for completeness of patients' records, it certainly is the duty of members of the visiting staff, at least to accept the responsibility for keeping these standards at a high level. Sometimes the physician delegates this duty to his assistant, but even assistant physicians grow weary of writing charts.

In a fifty-bed hospital, if it were possible to supply stenographic service, (and in an institution of this size one stenographer would certainly be sufficient) perhaps the dictation of these records by either the chief or his assistant would seem not too arduous a task. But even then, upon their completion by the stenographer, their accuracy must be attested to by some physician. Such a visé usually falls to the assistant.

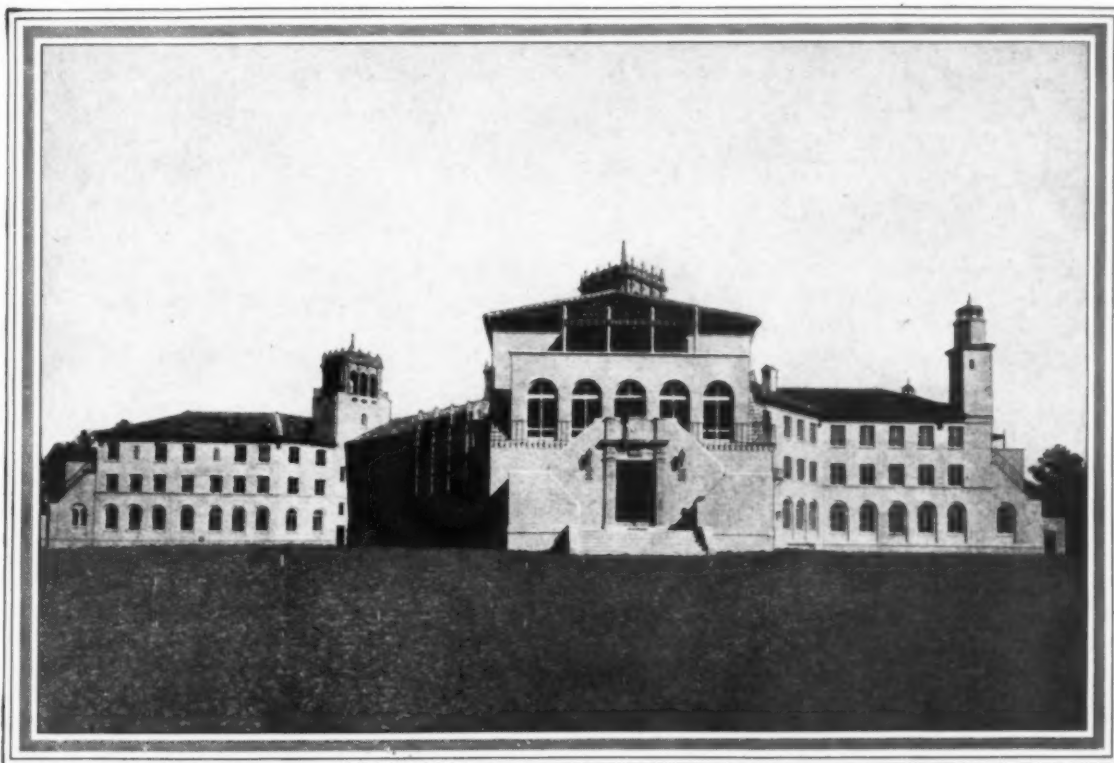
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The superintendent is perfectly justified in demanding of the chief that records be kept up to date. It does not concern the superintendent whether the chief delegates this work to his assistant or whether he inscribes the record himself. It has long been recognized that the visiting physician, even though interns and resident physicians are at hand, is, in the last analysis, not only responsible for the diagnosis and treatment of the patient's condition, but also for the compilation of proper records relative to this illness.

If the intern does not properly write his history, it does not appear that it is the superintendent's duty to reprimand him therefor. The superintendent justly should reprimand the visiting physician, or cause such to be done by the board of trustees when he neglects this duty. Nor should arguments by busy visiting physicians that the records of the private patients need not be as carefully compiled as are those of the ward patient, be given any importance. Every patient admitted to the hospital must not only receive careful and scientific study and treatment, but the results of this work should be placed on file in the hospital, and should represent a definite institutional property thereafter.

How Can the Proper Routine Examination of Urine Be Brought About?

There is no more tedious or time-consuming work required of the young physician, than the examination daily of large numbers of urine specimens. The intern often resents the performance of duties which, to him, are unprofitable because, as he says, he is learning nothing therefrom.

Examination of urine represents one of these disagreeable duties. It is feared that interns often fail to realize the importance to the patient of carelessness on their part in the examination of urine specimens. All over the medical world, the term "sink test" of urine, has come to describe neglect on the part of the intern in the examination of urine. The term "sink test," of course, denotes that the urine has been thrown into a sink instead of being properly examined. Interns sometimes hurriedly apply the heat or acid test for the presence of albumin, and in its absence carelessly record other facts in regard to the physical and chemical properties of the specimen.

Such an act on the part of an intern is of far greater significance than is the mere neglect incident to the examination of a laboratory specimen. It spells lowered morale and lack of ethical regard for the fundamentals in the practice of medicine. It means that an intern who will deliberately falsify a record is rather unsafe when it comes to carrying out some of the more important acts that his professional life will demand.

Nor does it seem a wise solution of this problem to suggest that the intern must be continually supervised while performing his laboratory work. The question strikes far deeper than this. It may mean that he has had improper instruction during his college days in regard to the ethics of medicine. It may imply that he is professionally dishonest. It may suggest that too much work is being required of him in too short a period of time. Whatever the cause, it is not without the bounds of reason to suppose that the patient may suffer or even that life may be lost, by careless, inaccurate, dishonest, laboratory methods. Nurses have been known to record temperatures when none have been taken.

All such unethical and untruthful steps during the hospital life of nurses and doctors, definitely injure their

spiritual make-up, and favor a repetition of such acts later in their medical lives. Punishment upon detection of such offenses should be prompt and severe. If such is not the case, inaccurate counting of blood cells or even the dishonest performance of blood chemistry examinations, may follow, and life may be lost because curative measures were not instituted in time.

What Should Be Done When an Intern Is Suspected of Ordering Unnecessary Treatment?

When personalities enter into institutional work the patient usually suffers. To one unacquainted with the conduct of hospitals, the ordering of unnecessary treatment for the purpose of increasing the nurse's duties, would seem impossible. Nevertheless, such a thing, or some variation of it, has occurred, and will, no doubt, recur in not a few hospitals.

A nurse has seen fit to report some major or minor apparent dereliction of duty on the part of an intern. The intern, giving way to momentary anger, decides that he will punish the student for so doing. He proceeds to order a long list of treatment, none of which will be harmful to the patient, but which, in his mind, has the virtue of being disagreeable or time-consuming to the nurse.

It is a difficult, indeed, sometimes an impossible task, to prove that such a motive actuated the ordering of treatment. Experienced hospital superintendents have been able, however, to satisfy themselves that if such a motive were not wholly responsible for the treatment, it had at least affected its type. Reference is made to the excessive or unusual prescription of salines or enemas, or of other similar therapeutic steps.

Here is an opportunity to apply a time-tried rule which should govern every act in hospital work. The tactful superintendent should clearly present to the intern and nursing staffs the proposition that none of the procedures carried out in the day's work is justifiable unless it will stand close scrutiny as to whether it advances the best interests of the patient. No true physician or nurse will willingly cause a patient discomfort or pain, or will, in any way, impede his convalescence.

Yet, youth is too often thoughtless, and as a result principles may be submerged in personalities. Sometimes such a problem can be solved through an interview with the intern or nurse concerned, the superintendent and the directress of nurses taking part therein. Of course, a repetition of this occurrence would require prompt disciplinary action.

This circumstance is just another convincing proof of the fact that the hospital owes a definite obligation to its young doctors and nurses in providing thorough yet sympathetic supervision of their work.

Should the Superintendent Who Is Not a Physician Attend Staff Meetings?

This question has been asked THE MODERN HOSPITAL by the superintendent of a seventy-five-bed hospital in the East. The staff members of this institution resent the presence of the superintendent at their meetings. They feel that he is appearing there as an eavesdropper and that he carries their discussions to the members of the board of trustees. They are unwilling to express their opinions in the administrator's presence as frankly as they should on matters that they consider of importance to themselves and to the hospital. They have on



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more than one occasion expressed the opinion that if the superintendent is to be present at their meetings, one of their number should be present at the meetings of the board of trustees. In other words, the members of the staff feel that it is their right to be as well informed relative to the proceedings of the board of trustees of the hospital as the latter body is posted as to staff deliberations.

Such a feeling cannot but be detrimental to the welfare of the patient. It can be stated without hesitation that the board of trustees must be in absolute control of the policies and procedures of the hospital. That any state of armed neutrality should arise between this governing body and the physicians who are actually giving medical care to the patients, is most unfortunate.

It has been frequently stated that it is not advisable to have the board of trustees number among its members, staff physicians. This rule has often been successfully altered, but as a general thing it appears wise for staff members not to hold the dual position of physician and board member. It ought to be possible for the superintendent of the hospital by supplying useful information at staff meetings, to improve the interest and efficiency of these deliberations. If the administrator cannot or does not command the whole-hearted respect of the members of the staff, and if his presence at their meetings is unwelcome, then it appears most wise for him to desist from such attendance. There should be no suspicion of spying upon either the meeting of the board of trustees or the medical staff.

THE MODERN HOSPITAL suggests that a meeting of all staff and board members be arranged at which a collation might be served, and at that time all misunderstandings frankly discussed. If it can be proved that the staff and the board have a common desire to benefit the patient, there certainly can exist no suspicion of selfishness on the part of either.

How Much Should Be Allowed per Horse Power for Boiler Repairs?

Too often hospitals construct modern power plants, and then do not set aside sufficient funds in their budget to keep them in repair. Dependent somewhat upon the type of plant, the variety of fuel and the stokers employed, will be the expense of maintenance.

It is a well known fact that the brickwork, constituting the arches and combustion chambers of boilers, must be replaced at certain rather definite intervals. No type of brick has yet been devised that will completely resist heat. In some commercial plants, it has been found that it costs at least one dollar per horse power per year to keep the brickwork in proper repair. At the end of a period of four or five years, boiler arches must be overhauled. Dependent upon the type of boiler used, will be the possibility of repair or the necessity of a complete rebuilding. This type of brickwork is rather a specialty and is, therefore, proportionately expensive.

Combustion chambers are subjected to great heat, and their brickwork must be periodically replaced. Some commercial plants find that the expense of maintaining brickwork greatly exceeds the above stated figure. In one large manufactory it was recently found that the expense for brickwork repair was three times the above amount, or three dollars per horse power per year.

Stokers are expensive to install and maintain, unless periodic overhauling and repairs are carried out.

If any type of coal conveyor or elevator is used, this

machinery will require frequent inspection and replacement of broken parts. Particularly if a bucket conveyor is used, the buckets themselves, as well as the guards and wheels, must be replaced from time to time.

The expense of replacing burned out boiler tubes will depend on how efficiently boiler water is treated and how often such tubes are mechanically cleaned. To allow scale to collect in boiler or tubes, is to prevent the greatest efficiency in the consumption of coal, as well as to favor the crystallization of the tube itself, and its resulting destruction.

While no definite rule can be laid down as to the amount of money required to maintain the boiler plant at its highest state of efficiency, because the skill of engineers and firemen enters as a deciding factor, yet, it may be said that to fail to keep such expensive machinery in proper repair, is to adopt a "penny-wise, pound-foolish" policy which, in the final analysis, is always costly.

Is the Development of Bed Sores Always the Fault of the Hospital?

Recently, the relatives of a certain patient made a serious charge of neglect against a general hospital because there developed a large bed sore upon the back of the patient under its care. This patient had received an injury to his spinal cord as a result of an automobile accident. The superintendents of the hospital and of the school for nurses were much concerned lest the public should come to believe that the hospital had neglected the patient, and that because of this fact alone, extensive necrosis of tissue had occurred.

It is a well known fact that injuries to the spinal cord are prone to bring about the development of bed sores, particularly in the region of the nerves that leave the spinal cord below the site of injury. Often the development of such an ulcer is absolutely unpreventable. It was so in this particular case.

On the other hand, bed sores may develop from pressure, as a result of not changing a patient's bed frequently enough, from the lack of bodily cleanliness, and from other causes, which are certainly preventable.

In the case of the development of lesions that occur from preventable causes, the hospital is without question at fault. Too often, the visiting physician or his intern does not pay sufficient attention to the prevention of such accidents or to the treatment of the ulcer, once it develops. The treatment of the backs of patients has too long been felt to lie wholly within the province of the nurse. To be sure, the care of the patient's back is one of the fundamental lessons that every good school for nurses teaches. Moreover, this care is always made more difficult by incontinence or by uncleanly habits on the part of the patient.

Even with these unfavorable conditions present, skilled nursing usually prevents the breakdown of tissue. Slothful nursing, which allows a patient to remain too long in one position, which does not continually provide a dry bed, which permits crumbs or other rough particles to remain in the patient's bed, is to be condemned, and the hospital in which such occurs, is to be criticized for any delay in the convalescence of the patient who develops bed sores from any of these causes. Medical testimony should be sufficient to absolve the hospital above mentioned from any blame. The occurrence, however, of such unpleasant events, often serves a good purpose by stimulating greater care in the prevention of these unfortunate occurrences in the hospital.



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NEWS OF THE MONTH

Newark Beth Israel Hospital Dedicated

The new Beth Israel Hospital, Newark, N. J., was dedicated February 19 and formally assumed its place as one of Newark's institutions consecrated to the relief of human suffering.

The building is regarded as an outstanding example of modern hospital construction, and represents an investment of \$3,500,000, of which \$3,000,000 had been contributed or pledged at the time the institution was thrown open. A campaign is being carried on for the remaining \$500,000 and it is expected that this amount will speedily be raised.

The hospital is a gift from citizens of the Jewish faith to the entire community of Newark. It will be operated as a nonsectarian institution, giving service to the rich and the poor of all creeds.

The superintendent of the hospital is Dr. Paul Keller.

A comprehensive article describing this institution, fully illustrated with plans and pictures, appears on page 67 of this issue.

Utica State Hospital to Give Course in Mental Nursing

The State Department of Education of New York has approved the plan of the Utica State Hospital and School of Nursing, Utica, N. Y., to give three months' affiliation to students from general hospitals.

Eighteen students will be taken in groups of six at a time, and during their period of training will live in the nurses' home at Dixhurst, N. Y. The subjects will concern mental defects, including intelligence tests, organic psychoses, toxic conditions, constitutional psychoses, psychoneuroses, psychotherapy, mental hygiene and mental nursing. In addition to the above, each student will receive a short course in occupational therapy, physical therapy and the work done in infirmary and convalescent wards. The hours of the course will be so arranged that the credits obtained may be used in college if the student so desires.

Robert E. Neff Goes to Iowa University Hospital

Announcement is made of the resignation of Robert E. Neff, administrator of the Indiana University Hospitals, Indianapolis, Ind., which comprise the Robert W. Long State Hospital, the James Whitcomb Riley Hospital for Children, and the Wm. H. W. Coleman Hospital for Women.

Mr. Neff has accepted a position at the University of

Iowa, Iowa City, Iowa, where the new \$4,500,000 medical and hospital plant will offer him outstanding opportunity in his particular field. He is widely known for his part in organization concerned with hospital administration and children's welfare work, and is president of the Children's Hospital Association of America, president-elect



Robert E. Neff.

of the Indiana Hospital Association and president of the Council of Social Agencies, Indianapolis.

In announcing Mr. Neff's resignation, Dr. Charles P. Emerson, dean of the medical school of Indiana University, expressed regret that Mr. Neff was leaving the Indianapolis hospitals where his work has been outstanding and highly valued.

Announce Building Program for Verona

Announcement was made in Newark, N. J., that the Freeholders had approved a two million dollar building program for the Essex Mountain Sanatorium, Verona, N. J. The plans include a 100-bed hospital, superintendent's residence, addition to employees' and nurses' quarters, a community house, laundry, fifty-bed hospital for aged incurables, a chapel and additions to the power house.

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Personals

DR. S. A. DOUGLAS has resigned his post as medical superintendent of the Franklin County Tuberculosis Hospital, Columbus, Ohio. He is now the field director of the National Tuberculosis Association.

MARGARET YOUNG has resigned from the superintendency of the Springfield Baptist Hospital, Springfield, Mo. Her successor has not as yet been appointed.

DR. VARNEY HAZELWOOD has resigned his position as superintendent of the Jasper County Tuberculosis Hospital, Webb City, Mo. Dr. Hazelwood will be succeeded by DR. J. E. DOUGLAS, Ah-Guah-Ching, Minn.

KATHERINE ST. GERMAIN has succeeded MRS. HATTIE A. JACKSON as superintendent of the Bide-a-Wee Hospital, Watertown, N. Y.

DR. J. H. GROSECLOSE is the new superintendent of the Methodist Hospital, Dallas, Tex. The building of the hospital, which is a five-story structure, was largely due to the efforts of the REV. J. A. OLD of McKinney, Tex.

DR. PANOS S. DUKAKIS has been appointed superintendent of the Boston City Hospital, Boston. Dr. Dukakis was the former assistant superintendent of the Providence City Hospital, Providence, R. I.

RUBY SHANER is to be the superintendent of the Crippled Children's Hospital which is being built in Richmond, Va.

DR. ISAAC J. FURMAN was appointed superintendent of the Buffalo State Hospital, Buffalo, N. Y. He has been in the service of the State of New York for the past fifteen years, and was last with the Manhattan State Hospital, New York.

J. STANLEY TURK has recently undertaken the superintendency of the Ohio Valley General Hospital, Wheeling, W. Va.

MINNIE J. HEHNER is no longer superintendent of the Leonard Hospital, Troy, N. Y. PALMA FERRARO is acting superintendent, but the position will be taken over by RUTH CALLISON, instructor in the school of nursing, in the near future.

NOAILES HAYES has succeeded MRS. ELIZABETH O'KEEFE COVERT as superintendent of the Major Memorial Hospital, Shelbyville, Ind.

OLIVE WEAVER has been appointed superintendent of the Grant County Hospital, Marion, Ind. E. J. KOLINDER, whom she succeeded, has accepted a position with the Auburn Park Hospital, Chicago.

DR. LYDIA HOLMES has resigned her position as managing director of Fairview Sanatorium, Normal, Ill. DR. CHARLES E. SHULTZ, formerly health director at Bloomington, Ill., has taken over her post.

DR. CRAIG BARROW, having served twenty years as head of the Georgia Infirmary, Savannah, Ga., resigned his position, and is taking up the management of the Central of Georgia Railway Hospital, in that town. He will be succeeded by DR. THOMAS J. CHARLTON.

MRS. CATHERINE MCGILL has resigned as superintendent of the Sapulpa City Hospital, Sapulpa, Okla. FRANCES SHAW is acting superintendent.

MRS. BEATRICE CUMMINGS has been appointed superintendent of the new municipal hospital for contagious diseases at St. Joseph, Mo.

DR. ROBERT E. GARRETT has succeeded DR. J. PERCY WADE as superintendent of the Spring Grove State Hospital, Catonsville, Md.

DR. EDWIN J. ROSE has resigned as superintendent of the United States Veterans' Hospital, Kansas City, Mo.

FRANCES M. NUNAN, formerly head dietitian, Loomis Sanatorium, Loomis, N. Y., has accepted the position of head dietitian, United Hospital, Port Chester, N. Y.

DR. B. W. BLACK has been appointed medical director of Alameda County, Calif., the appointment to be effective April 1. He will have general supervision of all county institutions and will fulfill the duties of superintendent of Highland Hospital, Oakland.

Dr. Hume to Be Director of New York Post-Graduate Hospital

The board of directors of the New York Post-Graduate Medical School and Hospital, New York, announces that Dr. Edward Hicks Hume, former president of the Colleges of Yale-in-China, and for many years identified with national and international hospital and educational work, has been appointed director of that institution.

During the past year Dr. Hume has been making a survey of the personnel and resources of the Post-Graduate Hospital, and he proposes to make certain changes in administration and teaching at the school. He also is planning a new building program.

During the forty-two years since the incorporation of the medical school, over 25,000 physicians have matriculated there.

The directors of the institution, appreciating the need of a new program adequate to the demands of advancing medical practice, have determined to build up for the institution such a program of medical opportunity in teaching and research and such a financial foundation, as will enable it more adequately to serve the field.

Plan Mental Hygiene Program for New York City

A survey has been begun by the National Committee for Mental Hygiene of all mental hygiene activities in New York City. The survey will include activities in the following fields: clinics, courts, schools, welfare agencies, institutions, and education and publicity. The New York City Committee on Mental Hygiene will use the results of this survey as a basis for a comprehensive program of work. The survey is being conducted by Elizabeth Greene, formerly psychologist for the Girls' Service League. She is acting under the direction of Dr. V. C. Branham, medical director of the New York State Committee and George K. Pratt, who represents the National Committee for Mental Hygiene.

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interval during the examination and in remarkably quick succession.

Fig. 3 shows the Fluorographic Control Unit, with which the operator may change instantly from a fluoroscopic to a radiographic current and back again to a fluoroscopy, simply by foot levers, and without having to leave his position at the screen. This unit has also the means for selective control of both voltage and milliamperage of the fluoroscopic current.

Bulletin 278, describing this equipment fully, will be sent on request.

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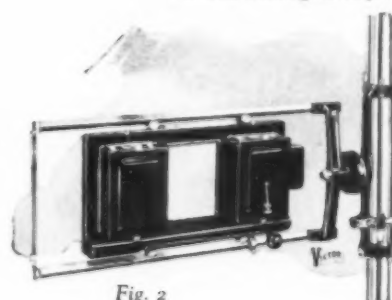


Fig. 2



Fig. 3

Among the Associations

Program Arranged for Protestant Hospital Convention

The annual convention of the American Protestant Hospital Association will be held in San Francisco, with headquarters at the Clift Hotel, August 3 to 6, 1928. The officers are looking forward to a successful meeting of the association, and have planned a comprehensive program with a view toward giving the delegates value for the time and expense involved in making the trip to the coast.

The program for the convention has been arranged, and among the prominent speakers on the program are: Albert J. Hahn, business manager Deaconess Hospital, Evansville, Ind., who will speak on "What Hospitals Are Doing Relative to Vacations, Sick Leaves, Discounts and Group Life Insurance." Workmen's compensation will be discussed by John H. Olsen, manager, Brunswick Hospital, Brooklyn, N. Y. A report on the recent investigation of the nursing situation will be given by May Ayres Burgess, director, Committee on the Grading of Nursing Schools, New York. A round table discussion will be conducted by Robert Jolly, superintendent, Baptist Hospital, Houston, Tex. Luther G. Reynolds, superintendent, Methodist Hospital, Los Angeles, will discuss the question, "Why a Church Hospital?" Rev. J. H. Bauernfeind, D.D., superintendent, Evangelical Deaconess Hospital, Chicago, will preside over a general discussion meeting. Dr. A. O. Fonkalsrud, superintendent, Sioux Valley Hospital, Sioux Falls, S. D., will speak on "The Spirit of the Present Day, and the Ideals of the Protestant Hospitals." Dr. C. S. Woods, superintendent, St. Luke's Hospital, Cleveland, and E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago, will also be in charge of round table discussions. The meetings will be presided over by Dr. H. L. Fritschel, superintendent, Milwaukee Hospital, Milwaukee, Wis., who is president of the association.

Opportunities for visiting several of the city hospitals have been provided, and entertainment of various sorts is being planned.

The speaker at the banquet will be Dr. Walter B. Coffey, chief surgeon, Southern Pacific Railroad Company. He will talk on the "High Cost of Illness, With Any Possible Remedies." Dr. Joseph C. Doane, president, American Hospital Association, Philadelphia, and Dr. Malcolm T. MacEachern, associate director, American College of Surgeons, Chicago, are to be the guests of honor.

Annual Meeting of Florida Hospital Association Held in Tampa

The annual meeting of the Florida Hospital Association was held in Tampa, January 26 and 27, in connection with the sectional meeting of the American College of Surgeons. The object of the joint meeting was to discuss hospital standardization in Florida.

On account of their outstanding services to the hospitals of the nation, the following visitors at the meeting were elected to honorary memberships in the Florida Hospital Association: Dr. Franklin H. Martin, director

general, American College of Surgeons, Chicago; Dr. Malcolm T. MacEachern, associate director, American College of Surgeons, Chicago, and Rev. C. B. Moulinier, S.J., president, Catholic Hospital Association, Milwaukee, Wis.

Mrs. L. B. Benham, inspector of training schools in the state of Florida, recommended that the Florida Hospital Association endorse a movement to standardize the pecuniary allowance to student nurses throughout the state, and to raise the educational qualifications of instructresses in nursing to the level of the standards of the general educational system of the state. Because of the importance of the question, it was decided to refer it to the resolutions committee of the association for investigation, and to ask this committee to prepare a report for the next regular meeting.

Hospital Social Workers to Celebrate Tenth Anniversary

Medical social workers from all parts of the country are planning to attend the annual meeting of the American Association of Hospital Social Workers to be held in Memphis, Tenn., May 1 to 9, in cooperation with the National Conference of Social Work. This meeting will celebrate the tenth anniversary of the organization of the American Association of Hospital Social Workers. Membership in the association has grown from the original thirty charter members to 1500.

The program this year will include the discussion in round tables of subjects under study by the various committees and districts of the association, and the presentation of material of general interest to social workers attending the conference.

Ida Cannon, director of social work, Massachusetts General Hospital, Boston, will lead a discussion on the subject "The Nonresident Patient." Medical social workers from several communities will participate in this discussion. Medical social workers in all parts of the country are facing common social problems resulting from the application of nonresidents for medical care in the large medical centers. This round table has been planned by Miss Cannon, chairman of the committee on community relationships, with the hope that by sharing experiences and freely discussing methods of solution, some general policies may be evolved.

Lena Waters, director of social work, University of Pennsylvania Hospital, Philadelphia, will lead a round table discussion on "Some Points on Organization of the Social Service Department."

Last spring, Miss Gordon Hamilton published an article in *Hospital Social Service* entitled "A Medical Social Terminology." This was the result of a study made at the suggestion of Dr. Hugh Auchincloss that a plan for a social service terminology be used as an appendix to the Lambert-Martin medical diagnoses classification. Several departments of medical social work have been using this terminology during the past year. It is hoped that Miss Hamilton will conduct a round table on this subject. This will include discussion of the results of these experiments in the use of the terminology.

Another meeting that will be of interest to medical so-



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Among the Associations

cial workers who are now teaching courses of social work to student nurses is a round table to be led by Agnes Schroeder, director of medical social work, School of Applied Social Sciences, Western Reserve University, Cleveland, on the subject "The Hospital Social Worker as a Teacher of the Student Nurse." Miss Schroeder has been collecting material for several months. This meeting is the outgrowth of a similar meeting held last year.

Irene Grant, director of social work, U. S. Veterans Bureau, will lead a discussion group on the subject of "Social Work in the Veterans Bureau."

Dr. Newton Stern, Memphis, Tenn., will be one of the speakers at a general session. Dr. Stern will speak on "The Contribution of Medical Social Worker to Treatment of Certain Diseases."

"Some Social Factors Influencing Medical Treatment of Ward and Dispensary Patients" will be the subject presented by a social worker.

The American Association of Hospital Social Workers has offered a prize for the best medical social case record submitted in a competition as selected by a committee. There have been two such competitions and another is being held this year. There will be a general session at which time the winning case will be announced and the committee's findings will be presented. Edith Baker, director of social work, St. Louis Hospital Social Service Association, St. Louis, Mo., will be in charge of the committee.

There will be joint meetings with the American Association of Psychiatric Social Workers, and with the health, family and professional standards and education sections of the National Conference of Social Work.

Members of the association who are not members of a local district organization will meet at dinner on Thursday evening, May 3, for discussion and for the planning for future development. Workers in hospitals and dispensaries in the undistricted territory are urged to attend this meeting.

Reservations for hotel accommodations should be sent to R. E. Logsdon, Chamber of Commerce, Memphis, Tenn. Special arrangements have been made with the railroads for transportation. Mrs. Janette Ricker Gaus, 1904 Kendal Avenue, Madison, Wis., is chairman of the program committee and Helen Russell, Memphis General Hospital, Memphis, Tenn., is chairman of the committee on local arrangements.

Further information may be obtained from headquarters office of the association, 18 East Division Street, Chicago.

New York Home Economics Association Meets

The March meeting of the women in business section of the Home Economics Association of New York City was held at the Mary Elizabeth Tea Room. The subject for the evening was recent publications of interest to women in business. The Misses Anderson and Fleming, owners of the Channel Bookshop, formerly with the U. S. Children's Bureau at Washington, D. C., who were scheduled to discuss the subject, were unable to be present, but they sent

a number of books for inspection. Mildred Bennett, a high school teacher of history and economics in New York, gave a brief outline of the contents and their application to the woman in business of the following books: *Influencing Human Behavior*, Harry Allen Overstreet; *About Ourselves*, Harry Allen Overstreet; *Short History of Women*, Langdon Davis; *Road to Plenty*, Foster & Catchings; *Economic Institutions*, Willard L. Thorp; *Your Money's Worth*, Chase & Schlink; *Political Myths and Economic Realities*, Francis Delaisi; *Economic History of the United States*, Harold Faulkner; *Imperialism and World Politics*, P. Moon.

Hospital Number of the Journal of the A. M. A. Published

In the March 24 issue of the *Journal of the American Medical Association* appears the first edition of the American Medical Association's Hospital Register, the result of a complete census of the entire hospital field, made by that association.

The hospitals listed in this register may be classified as follows:

1. The 6,807 hospitals and sanatoriums of all types and sizes in the United States that have been admitted to the American Medical Association's Hospital Register. Of these 4,322 are general hospitals; 563 are insane asylums and other nervous and mental institutions; 508 are tuberculosis institutions and 1,414 are hospitals of various other types.

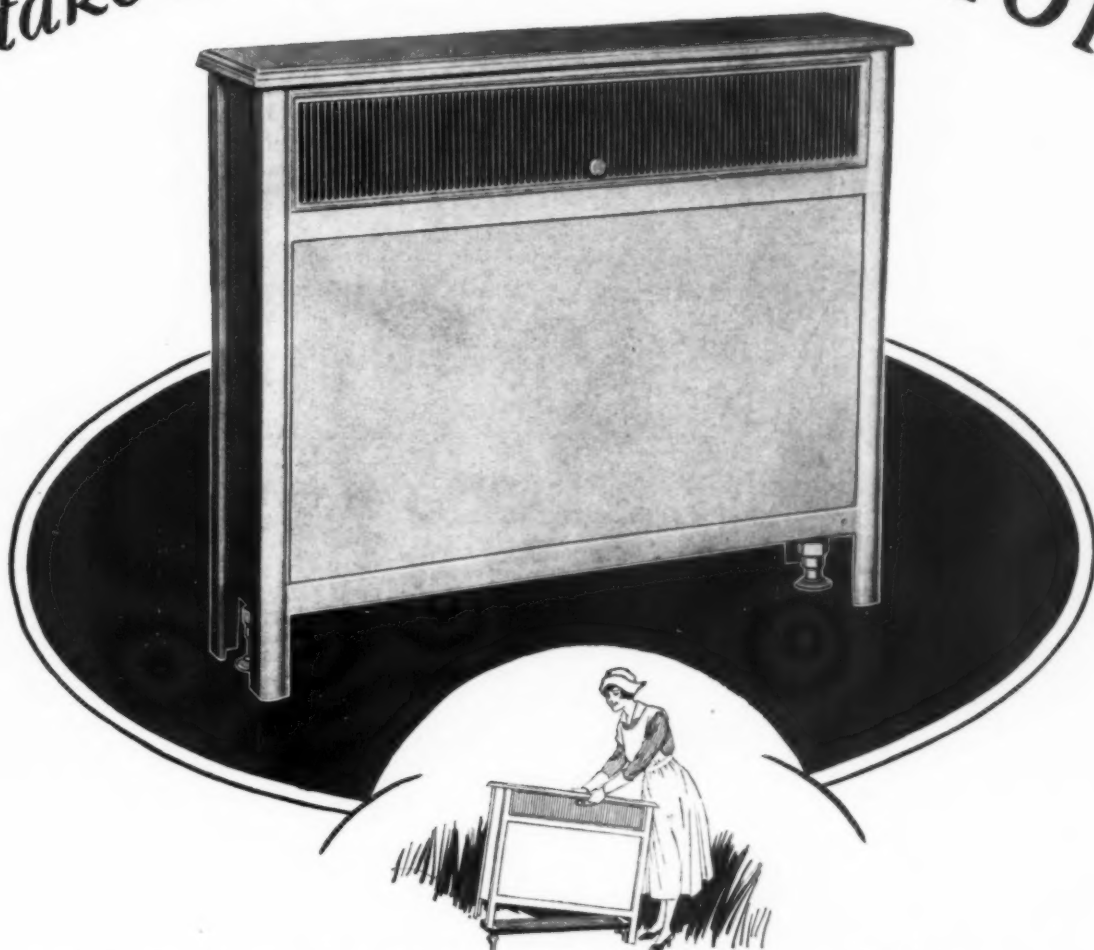
2. Hospitals that are on the approved list of the American College of Surgeons, having met the requirements of the standardization program of that organization. These hospitals number 1,543.

3. In the third group are 609 hospitals that have been found, after various reports and inspections, to provide the training of interns as required in the Council on Medical Education and Hospitals' "Essentials in a Hospital Approved for Interns." These hospitals seriously undertake to give a fifth year to instruction in medicine that in quality and content is comparable with the clinical instruction obtained by the student in his last two years in medical college.

4. The 292 hospitals that are approved for residencies in specialties by the Council on Medical Education and Hospitals. To be approved for giving residencies in specialties, the hospital agrees to appoint to those residencies only medical graduates who have already completed a general internship, or the fifth year in medicine.

From this list of registered hospitals have been omitted the names of 462 hospitals, which, according to the *Journal of the American Medical Association*, "have been investigated and disapproved because sufficient evidence showed that they carried on illegal practices or were otherwise unethical." Among the reasons for omitting these hospitals from the register are, for example, that they are controlled by persons known to be imposters or incapable either morally or professionally of providing efficient care for the sick or injured; those exploiting fad quack cures for cancer, consumption and the like, and those in which criminal or otherwise unethical practices are carried on.

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Among the Associations

National Hospital Day Suggestions

The National Hospital Day advisory committee of the American Hospital Association has suggested the following plans for observance of National Hospital Day, May 12, with a view toward bringing the public into better understanding and closer relationship with hospitals:

The board of trustees and hospital superintendent could request the Lions, Rotary, Kiwanis and other civic clubs to devote their weekly luncheons preceding May 12, to the presenting of a hospital program.

On the Sunday preceding May 12, the ministers of the different denominations should be requested to deliver a

sermon on the relationship of the hospital to the religious world, the need of hospitals in community life, and their mission in public welfare.

The mayor, his cabinet and members of the city council should be personally requested to visit the city hospitals and other like institutions on Hospital Day. In so doing, the city authorities would become familiar with, and gain a better understanding of hospital needs.

The newspapers and radio should both be used to the greatest possible extent as a medium for reaching the public with the news of Hospital Day and reasons for observing it.

School children should be invited to take part in the

Coming Meetings

American Association of Hospital Social Workers.

President, Mrs. Charles W. Webb, Lakeside Hospital, Cleveland, Ohio.

Executive-Secretary, Helen Beckley, 18 East Division Street, Chicago.

Next meeting, Memphis, Tenn., May 1-9.

American College of Surgeons.

President, Dr. George David Stewart, New York.

Director General, Dr. Franklin H. Martin, 40 East Erie Street, Chicago.

Next meeting, Boston, Oct. 8-12.

American Dietetic Association.

President, Florence Smith, St. Mary's Hospital, Rochester, Minn.

Business Manager, Dorothy B. Richmond, 25 East Washington Street, Chicago.

Next meeting, Washington, D. C., Oct. 29-31.

American Hospital Association.

President, Dr. Joseph C. Doane, Medical Director, Philadelphia General Hospital, Philadelphia.

Executive-Secretary, Dr. Bert W. Caldwell, 18 East Division Street, Chicago.

Next meeting, San Francisco, Aug. 6-10.

American Medical Association.

President, Dr. Jabez N. Jackson, Argyle Building, Kansas City, Mo.

Secretary, Dr. Olin West, 535 North Dearborn Street, Chicago.

Next meeting, Minneapolis, Minn., June 11-15.

American Protestant Hospital Association.

President, Rev. H. L. Fritschel, Milwaukee Hospital, Milwaukee, Wis.

Secretary-treasurer, Dr. Frank C. English, Christ Hospital, Cincinnati.

Next meeting, San Francisco, Cal., Aug. 4-6.

American Psychiatric Association.

President, Dr. Adolph Meyer, Johns Hopkins University, Baltimore, Md.

Secretary, Dr. Earl D. Bond, 4401 Market Street, Philadelphia.

Next meeting, Minneapolis, Minn., June 5-8.

American Public Health Association.

President, Dr. Herman N. Bundesen, Chicago.

Executive-Secretary, Homer N. Calver, 370 Seventh Avenue, New York.

Next meeting, Chicago, Oct. 15-19.

American Sanatorium Association.

President, Dr. Henry Boswell, Jr., Sanatorium, Miss.

Secretary, Dr. Walter H. Rathburn, Cassadaga, N. Y.

Next meeting, Portland, Ore., June 18.

Canadian Nurses' Association.

President, M. F. Gray, University of British Columbia, Vancouver.

Executive-Secretary, Jean S. Wilson, 511 Boyd Building, Winnipeg.

Next meeting, Winnipeg, July 3-4.

Catholic Hospital Association of the U. S. and Canada.

President, Rev. C. B. Moulinier, 124 Thirteenth Street, Milwaukee, Wis.

Secretary, Sister M. Bernadette, 124 Thirteenth Street, Milwaukee, Wis.

Next meeting, Cincinnati, June 18-22.

Hospital Association of New York State.

President, Col. Louis C. Trimble, New York.

Secretary, Dr. Marvin Z. Westervelt, Staten Island Hospital, Staten Island.

Next meeting, New York, May 24-25.

Hospital Association of the State of Illinois.

President, Dr. Paul W. Wipperman, Decatur and Macon County Hospital, Decatur.

Secretary, E. I. Erickson, Augustana Hospital, Chicago.

Next meeting, Chicago, April 24-25.

Indiana Hospital Association.

President, Dr. M. F. Steele, Hope Methodist Hospital, Fort Wayne.

Secretary, Missouria F. Martin, Muncie Home Hospital, Muncie.

Next meeting, Indianapolis, April 10-11.

Michigan Hospital Association.

President, Dr. Harley A. Haynes, University Hospital, Ann Arbor.

Secretary, Dr. Donald D. Morrill, Blodgett Memorial Hospital, Grand Rapids.

Next meeting, April 19-20.

Midwest Hospital Association.

President, Dr. B. A. Wikes, Missouri Baptist Sanitarium, St. Louis.

Secretary, W. J. Grolton, Missouri Pacific Hospital, St. Louis.

Next meeting, Kansas City, Mo., April 27-28.

Minnesota Hospital Association.

President, Dr. Ernest S. Mariette, Glen Lake Sanatorium, Oak Terrace.

Secretary, Dr. Donald C. Smelzer, Charles T. Miller Hospital, St. Paul.

Next meeting, Minneapolis, May 28-29.

Missouri Hospital Association.

President, J. R. Smiley, St. Luke's Hospital, Kansas City.

Secretary, W. J. Grolton, Missouri Pacific Hospital, St. Louis.

Next meeting, Kansas City, April 20-21.

National League of Nursing Education.

President, Carrie M. Hall, Peter Bent Brigham Hospital, Boston.

Executive-Secretary, Blanche Pfefferkorn, 370 Seventh Avenue, New York.

Next meeting, Louisville, Ky., June 4-9.

National Organization for Public Health Nursing.

President, Mrs. Anne L. Hansen, 181 Franklin Street, Buffalo, N. Y.

Director, Jane C. Allen, 370 Seventh Avenue, New York.

Next meeting, Louisville, Ky., June 4-8.

National Tuberculosis Association.

President, Dr. H. Longstreet Taylor, Children's Preventorium, St. Paul, Minn.

Managing Director, Linsley R. Williams, 370 Seventh Avenue, New York.

Next meeting, Portland, Ore., June 18-20.

New England Hospital Association.

President, Dr. Thos. S. Brown, Mary Fletcher Hospital, Burlington, Vt.

Secretary, Dr. Leslie H. Wright, Peter Bent Brigham Hospital, Boston, Mass.

Next meeting, Burlington, Vt., May 24-25.

New Jersey Hospital Association.

President, Dr. Paul Keller, Beth Israel Hospital, Newark.

Executive-Secretary, W. Crane Lyon, 201 Lyons Avenue, Newark.

Next meeting, Atlantic City, May 25-26.

North Carolina Hospital Association.

President, Dr. C. S. Lawrence, Winston-Salem.

Secretary-Treasurer, Dr. L. V. Grady, Wilson.

Next meeting, New Bern, May 16-18.

Ohio Hospital Association.

President, Dr. E. R. Crew, Miami Valley Hospital, Dayton.

Secretary, Robert G. Paterson, Columbus.

Next meeting, Toledo, April 17-18.

Wisconsin Hospital Association.

President, Dr. W. A. Henke, Grand View Hospital, La Crosse.

Executive-Secretary, H. K. Thurston, Jackson Clinic, Madison.

Next meeting, Chicago, April 24-25.

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Among the Associations

exercises and where possible, short talks should be given upon the relationship of the hospitals to the school children, upon the educational features of nurses' training, and upon the preparatory work which hospitals accomplish in medical education.

Every hospital should hold open house on this day, and during the afternoon a short program should be offered, after which the guests should be taken on a tour of inspection of the hospital.

The object of Hospital Day is to entertain the people of the community within the hospital walls; to demonstrate to them the enormous amount of work that the hospital constantly does to protect the community from being invaded by disease.

C. J. Cummings, chairman, National Hospital Day advisory committee, will present an award to the hospital making the best showing on Hospital Day. The award will be presented at the annual convention of the American Hospital Association to be held in San Francisco, August 6-10.

Clinics to Benefit Delegates to Catholic Convention

The Catholic Hospital Association in announcing its thirteenth annual convention this year for the week of June 18, at Cincinnati, also announces the Second Annual Hospital Clinical Congress, to be held in conjunction with the convention.

The idea of applying the principle of clinical teaching to hospital subjects had its origin and was first attempted last year at the First Annual Hospital Clinical Congress of North America, held in Milwaukee, Wis. It was at that time merely an experiment, and an attempt to impart to the delegates in attendance a bit of hospital education. It was successful in so far as an experiment of that nature can be, and the parties promoting the idea were so encouraged that they are planning a bigger and better clinical congress this year.

It is an indisputable fact that certain advantages are to be derived from the old type of convention, and last year's experiment has proved that there are also certain advantages to the clinical type. For this reason, the two are being combined in an effort to give the delegates the best service.

The clinics will be foremost in the program arrangement. They will cover in subject only important and practical problems of hospital work, but will be conducted in all hospital departments. The departments will be completely equipped and manned by outstanding specialists in the field.

Food Control Discussed at Dietitians' Meeting

The February meeting of the New York Association of Dietitians was held at the Russell Sage Foundation Building. A representative of the firm of Horwath & Horwath, accountants, New York, who specialize in hotel account-

ing, spoke on food control. While his talk was from the point of view of the hotel and restaurant, much that was said was applicable to hospital problems. The use as illustrative material of printed forms in common use in checking food costs against sales in restaurants made hospital dietitians realize how far they need to go in the developing of cost accounting systems in hospital dietary departments.

Illinois and Wisconsin Associations to Meet in Chicago

A joint meeting of the Hospital Association of the State of Illinois and the Wisconsin Hospital Association will be held in Chicago, April 24 and 25. Headquarters for the meeting will be at the Sherman Hotel.

Two great questions that arise in the management of any hospital have been chosen for the main subjects of discussion. "Business Methods in Hospitals" will be taken up at the first meeting. In connection with this subject, Clarence Baum, superintendent, Lake View Hospital, Danville, Ill., will present a paper on "What Are the Essential Requirements for an Efficient Business Department in a Hospital?" The questions, "Is It Advantageous for a Hospital to Operate on a Budget System?" and "How Would You Proceed to Prepare a Budget?" will be presented by William E. Coffey, manager, County Institutions, Milwaukee. "What Are the Best Methods for Preventing and Collecting Delinquent Accounts?" will be presented by John E. Ramson, superintendent, Toledo Hospital, Toledo, Ohio. "What Ways and Means Can Be Recommended for Meeting Annual Deficits in Hospitals?" will be discussed by Ada Belle McCleery, superintendent, Evanston Hospital, Evanston, Ill. Open discussion on these questions will be held by the following: H. K. Thurston, Jackson Clinic, Madison, Wis.; Charles F. Karrow, superintendent, Columbia Hospital, Milwaukee; Leo Von der Heide, superintendent, West Suburban Hospital, Chicago; J. C. Wollan, superintendent, La Crosse Lutheran Hospital, La Crosse, Wis. An open discussion will also be held by Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, on the questions "Is Hospital Service Too Costly?" and "What Are the Hospitals Doing for Patients of Moderate Means?"

The other of the two outstanding questions to be discussed is that of "Professional Problems in Hospitals." On this subject papers have been prepared by E. E. Sanders, superintendent, Ravenswood Hospital, Chicago, on "How Best Can Good Cooperation Be Maintained Between the Board of Trustees and the Medical Staff?" and by Dr. Malcolm T. MacEachern, associate director, American College of Surgeons, Chicago, on the subject of medical staff organization. A discussion by Dr. R. C. Buerki, superintendent, Wisconsin General Hospital, Madison, will treat the question of case records and ownership of x-ray films. Measures for insuring efficient surgery in a hospital will be presented by Dr. O. R. Nadeau, attending surgeon, Augustana Hospital, Chicago, and Dr. Frank J. Novak, Lake View Hospital, Chicago, will discuss the hospital's ability to increase postmortems.

Dr. P. W. Wipparman, superintendent, Decatur and

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Among the Associations

Macon County Hospital, Decatur, Ill., president, Hospital Association of Illinois, will preside over the first meeting. The other meetings will be presided over by Dr. W. A. Henke, La Crosse, Wis., president of the Wisconsin Hospital Association, and Dr. Joseph C. Doane, president, American Hospital Association, Philadelphia.

A luncheon of the association will be presided over by Dr. Bert W. Caldwell, executive secretary, American Hospital Association; and at an informal dinner, James A. Patten, member of the boards of trustees of the Evanston and Presbyterian Hospitals, will preside. The addresses at the dinner will be by Dr. Doane and Rev. C. B. Moulinier, president, Catholic Hospital Association, Milwaukee.

Discussions on how to save money in the hospital will be given by the following: H. R. Haupt, Decatur and Macon County Hospital, Decatur, Ill.; W. M. Krieger, Insurance Company of North America, Chicago; B. W. Jones, Presbyterian Hospital, Chicago; Dr. P. W. Wipperman, L. C. Austin, superintendent, Mount Sinai Hospital, Milwaukee, and Dr. Bert W. Caldwell.

Louisville Chosen for Biennial Convention of Nurses

Seven thousand members are expected to attend the Biennial Convention of the Three National Nursing Organizations to be held in Louisville, Ky., June 4 to 9. Members of the American Nurses' Association, the National League of Nursing Education and the National Organization of Public Health Nurses will take part in the sessions and a number of lay workers also will attend, the inclusion of the latter group on the program and in the sessions of the National Organization of Public Health Nurses, being the first official recognition of the lay worker at a convention of that group.

Headquarters of the convention will be in the Jefferson County Armory and detailed plans of arrangements can be obtained from the national headquarters of the American Nurses' Association, 370 Seventh Avenue, New York.

Half the floor space of the Armory has been set aside for a commercial exhibit, about a hundred displays having been arranged of commodities of interest to nurses, such as hospital supplies, uniforms and canned goods. Several insurance companies also will have booths, insurance for nurses being one of the important problems at this time. These companies will have representatives to explain insurance practice and their company methods to all convention comers.

Louisville is noted for its hospitality and the local committee already has formulated elaborate plans for the entertainment of the nurses. Three major affairs have been planned, a garden party at Central Park, a boat ride on the Ohio River and a horse race, arranged especially for the nurses, at the famous race course, Churchill Downs. There are opportunities also for side trips both in Louisville and near by, and a registration desk will be maintained at the Armory for nurses wishing to make these trips.

As plans mature for the convention, two distinct phases are evident in the programs. The first is based on

educational problems; the second, on redistribution of nursing service in terms of modern living and modern business methods.

"Adult Education" will be the subject of Dr. Charles Hubbard Judd, head of the department of education at the University of Chicago, who will be the principal speaker at the opening meeting of the convention, Monday evening, June 4.

Brief talks will be given by the presidents of the three organizations and by Clara D. Noyes, national director of the nursing service of the American Red Cross, Washington, D. C.

"Education of the Nurse in Service," will be the subject of a discussion group under the National Organization of Public Health Nurses with Amy Grant as chairman. Miss Grant is the director of the newly created Bureau of Public Health Nursing, New York City. Also under the National Organization of Public Health Nurses will be the conference meeting at which Harriet Frost of the Philadelphia School of Social and Health Work will discuss "Summer Institutes."

The thoughts of all attending the convention will turn to considerations of the American Nurses' Association as well as other groups on hourly and group nursing and the work of registries. Always an important factor in the lives of private duty nurses, the registry has assumed an added significance during the past several years.

Dr. May Ayres Burgess, director, committee, will give her report on the findings of that committee which now is in the second year of its five-year survey.

The survey was undertaken with the expectation of bringing into clear relief the situation in the nursing profession today. It is hoped that with a comprehension of existing conditions, needs and tendencies resulting from this study, a program may be evolved that will adapt itself through modern methods to modern nursing needs, and will by opening new avenues of service, give broader scope to the ideals and aims of nursing.

Trachoma Hospital Established in Kentucky

The Kentucky State Medical Association has lent to the U. S. Public Health Service for use as a trachoma hospital the former home of Mrs. Elizabeth Irvine, Richmond, which she bequeathed to the society as a memorial to her grandfather, Dr. Ephraim McDowell, according to the *Journal of the American Medical Association*. The building was altered and equipped to accommodate thirty patients. During the first year it was opened, patients were received from forty counties in Kentucky and from three other states, the total number treated in that year being 167 admitted and 869 out-patients.

Trachoma work in Kentucky was resumed with the establishment of this hospital at Richmond, at the urgent request of the state health department. Trachoma hospitals had been established in various localities following surveys made by the public health service in 1912, but the last of these hospitals in Kentucky was closed in 1924.

(Additional news items appear on page 174)

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NURSING AND THE HOSPITAL

Conducted by M. HELENA MC MILLAN, R. N.,
Director, School of Nursing, Presbyterian Hospital, Chicago

Extra-Curricular Activities Broaden the Nurse's Life

By RACHEL McCONNELL, R.N.

Principal of the Nurses' Training School, Hartford Hospital, Hartford, Conn.

THE subject of extra-curricular activities in schools of nursing is engaging the thoughts of many who are interested in the lives of student nurses. We so often hear the questions, "Have you enough students?" and "How is it possible to enroll the proper type of young women?" that we have begun to pay considerable attention to the life of the student and to realize that it is not altogether the education she receives, but the teaching plus the interest that is manifested in her personal life that makes her consider the field of nursing.

Let us therefore divide the subject into three head-

ings: First, the need for extra-curricular activities; second, organization of these activities; third, results obtained.

In considering the need for extra-curricular activities, two pictures are presented to us, one, the nurse of the past, and the other, the nurse of today.

The first picture presents one of self-sacrifice on the part of the nurse, of long tedious hours of ward duty, of hours spent in studying after ward duties are finished for the day, with little or no time for recreation. It seemed to me as a student that one side of the nurse's



Nurses' residence, Hartford Hospital, Hartford, Conn.



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The assembly hall of the nurses' residence.

life was sadly neglected. She came to the school full of enthusiasm because of her desire for service, but during those days of training, little was done for her along lines of social enjoyment, so that her life became stunted and she lost sight of the many joys that other people participated in. She was expected to be pleasing to her patients, to give them the best of care, to be a comfort to suffering humanity, to be accurate in every detail and to suppress her own troubles.

Little wonder that nursing was thought of as a hard life, and that so few nurses really advised their friends to enter the field. All honor is due to those who withstood the test.

But the scene has changed. Today there are many professional and business inducements offered to young women, so that if the nursing profession is going to fill its ranks with women of the right type, thought and consideration must be given to the development of their social as well as to their educational lives.

Let us consider for a moment the school where there are no activities. We find that the student enters her room after duties have ended. She reviews the day. It has been a difficult one. She planned her work poorly, her patients were more exacting than usual in their demands, the head nurse was not satisfied with her efforts. Summing up the whole day, it has been one of failure. She visits her neighbor, tells her story of the day and finally goes to bed feeling that her lot is not an enviable one, and on the following morning she goes back to work still feeling that the world is against her.

On the other hand, when she finishes for the day she suddenly remembers that she is a member of the school glee club and has just time to get ready for weekly rehearsal. So she forgets the day, with its worries and disappointments, and finds herself amongst a group of nurses who are having an enjoyable hour of music, with the result that joy takes the place of sorrow, her whole trend of thought changes and she goes back to her patients on the following morning filled with fresh energy. Students require diversion, as the routine life of a nurse is narrowing. School activities are necessary to develop the social

life in a school of nursing, to create leaders, to give the students an appreciation of the world outside and to assist in advertising the school, for the students are the best advertisers.

In organizing the activities in a school of nursing we must ever bear in mind that the activities must suit the needs of the particular school. It is not possible for all schools to have the same activities, because surroundings, equipment and size vary, but it is possible to introduce one or two activities in any school of any size.

The pioneer work is not easy and must be done slowly, therefore the person on whom this responsibility is placed must have faith in the results that can be accomplished, must be prepared to face difficulties and must ever stand in readiness to show interest in any project that is brought before her. There are few schools fortunate enough to have a social director, so that the superintendent of nurses can play a big part in encouraging and often directing the various activities to be indulged in, until the officers chosen are capable of taking charge.

Glee Club Is Formed

In the Hartford Hospital, Hartford, Conn., we realized that we had several graduates of the school and students who had good voices and were deeply interested in music. These were approached about forming a glee club, with the result that on October 28, 1925, the club was organized and the services of a trained director and accompanist were secured. Officers were chosen and a set of rules compiled regarding membership, duties of officers, dues, rehearsals and various committees. Since the organization of the club four concerts have been given, the club has broadcast three times from the local broadcasting station and last year the treasury showed an income of over a thousand dollars, which was used to defray the expenses of the club. The organizing of the glee club disclosed the need of a new piano, and through the interest of our superintendent, Dr. L. A. Sexton, the directors of the hospital presented a beautiful baby grand piano to the school.

Pineapple and Orange Salad

Arrange crisp leaves of lettuce on a plate. Place thin slices of orange around the plate with a ring of Libby's Hawaiian Pineapple on top. Serve with mayonnaise to which chopped green pepper and celery have been added. Garnish with strips of pimento

An inexpensive variation for the ward diet

Mix equal parts of Libby's Crushed Pineapple and shredded cabbage with mayonnaise. Fill a lettuce cup with salad, and garnish with bits of Maraschino Cherry or nut meats

A favorite with private patients

Split small, rich baking powder biscuits. Spread with a layer of Libby's Crushed Pineapple, thickened. Close the biscuit and spread a second layer of pineapple on the top of the biscuit. Top with whipped cream



Even *critical* patients praise this inviting salad

A simple pineapple dish that tempts finicky appetites

What a problem they are—those hospital dishes that must be tempting, yet light and nourishing as well! One well-known dietitian says she finds a popular solution lies in certain ways of serving pineapple. Practically no diet excludes it, and even critical patients grow enthusiastic when it is used in a dainty salad like the one described here.

To have the full, delicate sweetness that is so enticing, pineapple must be allowed to ripen in the fields to the moment of perfection. Knowing this, many dietitians insist on a particular kind of pineapple that has been fully ripened and packed at once in a model kitchen—Libby's Hawaiian Pineapple.



In far-away Hawaii Libby owns 8,000 acres of the world's finest pineapple producing land. There, on Libby's own plantations, the harvesting of the fruit is carefully controlled so that the pineapple is gathered only when fully ripe. Owing these great plantations and model kitchens in their midst, Libby assures you of pineapple with all the enticing flavor of the fresh fruit.

Pineapple is only one of the choice foods Libby grows and packs with such thoroughness. Equal care is given to all the 100 Foods that bear the Libby label. A partial list is printed here—order some now and see how tempting they make your trays.

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Red Raspberries
Tomato Purée
Pork and Beans
Olives
Pickles, Mustard
Bouillon Cubes
Beef Extract
Catchup, Chili Sauce
Salmon
Evaporated Milk
Mince Meat
Boneless Chicken

The following year a request for a dramatic club came from members of the school who could not sing, and upon investigation it was found that there was enough talent in the school to form a club. A dramatic coach was invited to interview the students who were interested and she decided that the organizing of such a club would be beneficial to its members. Rules similar to those of the glee club were drawn up and the club gave its first annual production in the Spring of this year. Much enthusiasm was shown in the club and before the year closed, we found that we had amongst us actresses, designers, dressmakers, stage managers, property managers and others with varied gifts.

Y. W. C. A. Cooperates

At the same time a request came from those who could not sing and who could not act, to be permitted to organize a basket ball team, and after the usual preliminaries of finding out the degree of enthusiasm shown and the strength of the desire to play, the secretary of the Y. W. C. A. was approached regarding a coach, and the use of the gymnasium belonging to that organization. A team was then organized and a successful winter's sport was much enjoyed.

When our activities were renewed this Fall, a meeting of the officers of the various classes was held and discussion followed as to whether the needs of the whole student body were met by the three clubs. It was decided that there was a group who could not sing, act or play basket ball, but who wanted to feel that they were included in the activities, and there was another group who did not want to take part in anything but were contented to enjoy all the privileges afforded them by the various clubs. In order to cover the whole situation, it was decided to form an activities association, to which all the members of the school would be obliged to belong, thus giving strength to the various clubs by having the support of one big association, and giving members who were not already in any of the clubs of the school an opportunity to form any other club, such as a current event or literary club, as the demand arose.

In all of these clubs officers are chosen who assume responsibility as president, vice-president, secretary and treasurer, also chairmen of different committees, such as publicity, membership, social and sick. The development of individual students in the various clubs has been remarkable.

These activities are financed by an initiation fee of fifty cents, weekly dues of ten cents from each member, and proceeds from concerts given.

The superintendent and directors of the hospital have taken a vital interest in all the activities of the school and always stand in readiness to assist financially. In addition to this interest, the gift of our beautiful Heublein Memorial Assembly Hall has assisted us in our accomplishments and we are ever grateful to the donors for their generosity.

There are other activities in the school, such as the Big Sister Movement and Community Night, both of which play a vital part in the life of the student. Big Sisters are chosen from the senior class and adopt probationers or Little Sisters when they first enter the school. They are obliged to take the following pledge to their Little Sisters:

"I promise to you, my Little Sister, to endeavor to be an example of womanliness, integrity and uprightness, worthy of my school, to assist you to overcome any difficulties that you may encounter and to make our school one of many pleasant memories."

In order to be a Big Sister a student must give evidence of common sense and ability, because of the responsibility imposed upon her; those who do poor work, or whose deportment in the school might be criticized are not permitted to adopt a Little Sister.

At the completion of the preliminary term our Capping Party is eagerly looked forward to. Big and Little Sisters form in fours and march into our assembly hall, the Big Sisters marching in the two outside rows and carrying their Little Sisters' caps, all ready to be pinned on. After a short talk and congratulations on their achievements, the Big Sisters are asked to pin the caps on their Little Sisters, which is always an exciting event.

Community Night is held once a month for the purpose of bringing to the attention of the students anything that might benefit the school or be of detriment to it. Promotions from one class to another are made at this time, for no student is allowed to advance until all examinations have been passed.

Announcements are made regarding new developments in the school, and other details concerning the deportment of students are discussed. After business has ended, the remainder of the evening is given over to each class of students in turn, who put on a program and serve refreshments, much to the enjoyment of the rest of the school. Community Night is always eagerly looked forward to.

There are several other activities that might be introduced into the life of the nurse.

School activities make the students happier, give them wider opportunities for development and teach them an appreciation of the many beautiful things outside their own lives as nurses. They also create leaders and develop latent ability.

Such activities advertise schools of nursing as proper institutions for training girls, not only to become nurses but to become real women and useful citizens. They fill students with enthusiasm about their own school, so that they are ever ready to recruit their friends to enter their school.

Lastly, school activities indirectly benefit the patients by sending happy, cheerful students on duty, whose chief desire is to do all in their power to comfort, encourage and nurse their patients back to health and strength.

Ill Will of Patients Easily Aroused

Necessary as is efficiency in ordinary commercial accounting, it is even more necessary in the business office of a hospital, said Charles Morrison, accountant, Provincial Royal Jubilee Hospital, Victoria, B. C., in a paper recently presented to the British Columbia Hospital Association.

The business man as a rule is dealing with normal people, and if any controversy arises, all he has to do in order to prove his point and restore good feeling, is to present facts. The hospital staff, on the other hand, is dealing with sick people or their relatives, all more or less worried, and therefore peculiarly sensitive to imaginary, or at least, unintentional slights. A single curt or sharply worded sentence may destroy the good feeling toward a hospital which, perhaps, it has taken weeks or months to create. In the same manner, a slight overcharge due to an error in the accounts, might create a feeling of ill will which later on would cause the patient to speak bitterly of the hospital. Thus every care must be taken to keep the accounts perfectly accurate.

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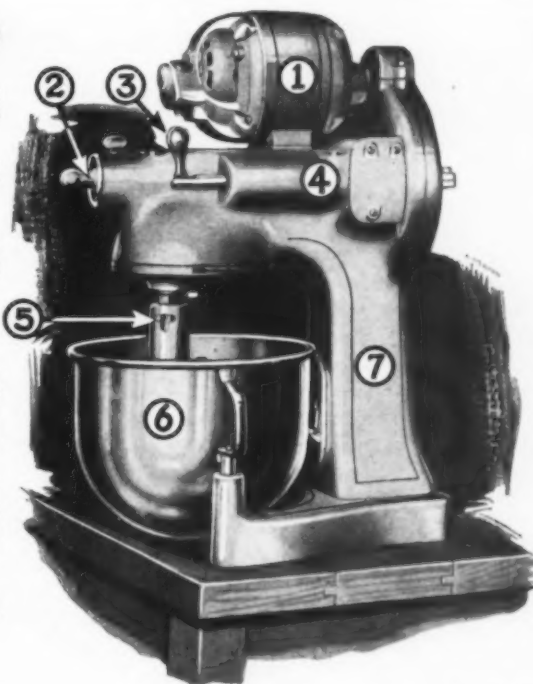
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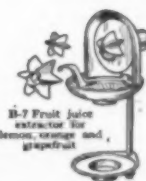
B-4 Combination vegetable slicer, crumber and grater



B-5 Mayonnaise oil drip



B-6 Tool sharpener



B-7 Fruit juice extractor for lemons, oranges and grapefruit



B-8 Coffee and spice grinder

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES, 7 East 54th Street, New York, MARY A. FOLEY, Director of Dietetics, Kahler Hospital, Rochester Minn. and S. MARGARET GILLAM, University Hospital, Ann Arbor, Mich.

Yardsticks for the Dietitian

By R. N. BROUGH

Superintendent, Homeopathic Hospital of Essex County, East Orange, N. J.

THE administration of hospitals is constantly subject to attack. Many uninformed persons are apt to raise impossible standards and to criticize the hospitals when these are not met.

Suggestions have been made that authoritative standards of hospital administration be established, for comparison and guidance. E. H. Lewinski-Corwin, director, Hospital Information and Service Bureau, New York, in a thoughtful paper, published in the December, 1927, issue of *THE MODERN HOSPITAL*, outlined means by which hospital productivity can be measured as a whole.

How about the dietary department? It is responsible for one-fourth to one-third of the cost of maintaining hospitals. On an average, thirty cents of every dollar received is spent for feeding patients and employees. If we are to measure a hospital's work, obviously we must include dietetics, and if we can measure the efficiency of the dietary department we have limited the problem and made real progress.

General terms will not do; definite measuring rods are needed. We should be able at any time to make a survey of a dietary department and give it a rating according to approved standards. The following schedule is an attempt to provide just such yardsticks. They are not intended to be final; further research will undoubtedly set up better and simpler methods of determining dietary efficiency. The measuring rods given below are, therefore, tentative, blazing the way toward what in time will become an established and accepted pathway through the maze of institutional dietetics.

Visualizing the Department

First, let us visualize the dietary department as a whole. What is its place in the hospital? Is it merely the kitchen, or does it function as one of the major departments? The 100 per cent dietary department prepares and serves food for patients and employees with efficiency and satisfaction, teaches dietetics to students and nurses, is an aid to the physician in various branches of dietotherapy, and is a real force in the community in spreading the gospel of good food and good health. It maintains contacts with both in-patients and out-patients, making valuable dietary suggestions. The dietitian in charge has a professional standing and is not merely an employee subject to censure for all real or imaginary food faults. She sees that full cooperation is extended to all other departments in the

hospital; and, above all, she makes sure, on the basis of facts, experience and comparison, that the best possible food is served at the lowest possible cost. All angles of food purchase and preparation come within her ken. Service, satisfaction, economy are the watchwords.

Having looked at the dietary department as a whole, let us make a more detailed analysis with the idea of determining along ten definite lines, the scope and value of the work that is being done.

There are ten practical yardsticks, to each of which has been given a score showing its relative importance. On this basis a perfect dietary department (if it exists) might be given a total of 100 points.

Service Standards	Points
1. Cleanliness	10
2. Quality of Food.....	10
3. Quality of Service.....	10
4. Post-Stove Time	10
5. Completeness of Task.....	10
Other Standards	
6. Cost	20
7. Waste	10
8. Complaints	5
9. Teaching	10
10. Progress	5
Total points	100

The standards by which the service rendered may be measured are outlined and described as follows:

1. Cleanliness: An age-old principle. There is a special and fundamental obligation upon hospital dietary departments to be clean in every respect. This includes equipment and personnel. To make sure of real food cleanliness and sanitation, there should be:

a. A thorough cleaning of the kitchen and kitchen equipment each day.

b. A weekly or more frequent inspection of the kitchen and all dietary equipment, including refrigerators, made with military thoroughness and an insistence upon genuine cleanliness, based upon common sense standards.

c. A semiannual physical examination of all employees handling, preparing, touching or serving food, as well as a similar examination when each new employee is engaged.

To make the above possible there should be an insist-



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ence upon proper equipment. A kitchen cannot be really clean with old, water-soaked sink drain boards and countless lurking places for roaches or pests. This is but one illustration which any competent dietitian can readily amplify. Effective cleaning agents should be provided, which must be purchased with thought and care. In this connection be wary of the enthusiastic salesman, whose product is used "everywhere" and which will clean everything or anything. Elbow grease is a rare commodity nowadays; we must supplement it with the best mechanical agents the market affords.

2. **Quality of Food:** Here the rating is based upon the prepared food as it reaches the individual, not primarily upon the raw food purchased. It is assumed that any dietary department worthy of the name purchases satisfactory and good quality. But good food is often spoiled in cooking. Therefore, the question to be answered is, "Does the prepared food, as served to the ultimate consumer, have satisfactory quality?"

This is perhaps our most intangible yardstick and the most difficult to handle. We must get the answer not through personal belief, but by impartial inquiry addressed to fair-minded patients and employees. Ways of doing this will readily suggest themselves. The investigation and the rating might well be made by someone not in the dietary department, so as to avoid any possible prejudice.

"Satisfactory quality" is in itself indefinite. Meals of excellent quality to ward patients in one hospital would be almost unedible to private room patients in another institution. The task of the dietary department is to satisfy those it is feeding, and they are the ones who should give answer. To secure a result that is approximately correct we must learn the mature judgment of a number of people, and in doing so it is well to remember that we cannot satisfy "all of the people, all of the time."

The question of quality also involves proper diversity of menu. Good food soon loses its appeal if variety is lacking. A review of the menus during a month will readily give a satisfactory answer on this point.

Under this heading consideration should also be given to the food flavor. The nearer we come to a true "home cooked" taste, the higher should be the rating. The importance of exact and suitable seasoning of institutional food has not been sufficiently emphasized. A food consultant recently stated in writing, "I cannot see what the special 'home cooking' flavor applies to. Steaks, chops, roasts, baked potatoes, mashed potatoes and vegetables cannot be cooked any other way, because the cooking is so simple." Such comment is surprising, to say the least. All of us know the difference between a meal in a well managed tea room and one in a second-class hotel dining room or restaurant. In fact, the country is dotted with tea rooms whose success is due in a large measure to the fact that restaurants had lost the art of "home cooking." Many a housewife and many a food connoisseur will say that the essence of cooking lies in proper seasoning.

Food Must Be Attractively Served

3. **Quality of Service:** Food must be attractively served or it will be rejected by patients. The dining rooms must be well supervised, reasonably quiet, adequately provided with waitresses, and properly equipped, or employees will be dissatisfied and their efficiency lessened. As much thought and supervision is required for food service as for food preparation. This final step is not always given its due importance. The type or method of service, whether centralized or noncentralized, is of no importance except as it affects the quality of the service.

Two cardinal points must be stressed, however. Satisfactory transportation must be provided, and second, the scheme of hospital management should be such that nothing will interfere with the service of food. The nursing routine, the ward rounds, the doctors' visits to private patients, must all be properly adjusted to food service, so that the patient reaps the reward of the efforts of the dietary department.

4. **Post-stove Time:** By this we mean the time required for the food to pass from the stove to the patient or employee. This should be regarded as "lost time." In the home, the food goes directly from the stove to the table, and woe to the individual who causes delay after the meal is ready to serve! In most of our hospitals there is too much time lost between the stove and the bedside. True, physical conditions often cause this delay, and the best must be made of a bad situation. Nevertheless, cooked food does lose its flavor and appeal, by standing or being kept hot by various methods. So we must rate our departments fairly and squarely with that truth in mind. For statistical purposes a "post-stove time" of five minutes is ideal and scores ten points. By "stove" we do not mean steam tables, food carts, or other reheating points, but rather the original point of cooking. Each ten minutes lost beyond the first five would cause a loss of one point.

Months ago the writer inspected the kitchen of a 400-bed hospital, where the meat for ward patients was practically cooked at ten-thirty in the morning, though it did not reach its destination until about twelve o'clock. It was kept warm by steam tables and food carts in the meantime. The management seemed to be satisfied, but the result was poor from the standpoint of the patient.

Department Has Three Tasks

5. **Completeness of Task:** The dietary department is properly charged with three primary tasks—purchasing, preparing and serving food. The three steps go together and should be synchronized under one head. If for any reason the dietary department is not performing or controlling the three functions, there is either an unusual local condition or some record of failure in the past that has taken away from the dietitian part of her proper sphere. At any rate there is an impairment of function that should be noted in our point tabulation.

One exception to this rule holds good: In large hospitals where there is a purchasing department or a purchasing agent with requisite skill and experience, the actual food purchasing may be done by that department on requisition of the dietitian, with advantage to all concerned. If the system works well and raw food of good quality is secured at low prices, a perfect score may be attained for the point now under consideration.

The second test is: "Does the dietary department perform all of its proper functions in a smooth, satisfactory manner?" An affirmative answer will give a score of ten points.

6. **Cost:** Now we have reached the question of finance, which looms so large on the hospital horizon. After all, money talks. The financial test is important. It has therefore been given a rating of twenty points.

How shall we determine the ideal or proper cost of meals served? It varies greatly in different institutions, and a low cost in a private hospital would be excessive in a large state institution caring for indigent patients. Likewise a low cost in one section of the country might be high in another, and so on. Each institution must arrive at its own proper meal cost, after investigation and comparison with other similar hospitals in the same ter-



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ritory. After this has been done, there should preferably be established a dietary budget, fixing the average cost of meals served, taking all elements of expense into consideration except the general overhead charges, with which the dietary department has nothing to do.

As an average, hospitals should have a meal cost today of about twenty-six cents. Large hospitals, producing 75,000 or more meals monthly, may do better. Likewise, religious hospitals, in which part of the labor is performed by Sisters or Deaconesses at low rates of pay, will go below this figure. Hospitals close to farming regions may also realize a substantial economy.

The meal cost figure established as a standard should include the following elements of cost, and the three classes of expense should be about as stated:

Elements of Meal Cost	Cost Per Meal Served
Food, including all kinds.....	18 cents
Payroll, including dietitians and all employees of dietary department.....	06 cents
Other expenses, including gas, fuel, renewals of dishes and equipment, and all miscellaneous expenditures	02 cents
Total cost	26 cents

After this figure has been properly adjusted as previously outlined, four points in the rating should be added for each cent saved in the average meal cost. Likewise each cent of increased cost should reduce the score by four points. For instance, if a hospital knows by investigation and comparison that its meal cost should be twenty-five cents, and the average cost for January is twenty-seven cents, it would score twelve out of the possible twenty points.

Seasonal fluctuations in cost can best be disregarded as a practical matter. During the winter and early spring, when costs are high, the ideal is not attained and the rating might just as well show the fact, even though there is no actual decrease in efficiency. Theoretically, however, there is no objection to a seasonal adjustment of the basic cost figure, if anyone cares to work the problem out in a scientific manner.

The meal cost figure takes into consideration all meals served, both to patients and employees. The count should be reasonably accurate, and should be verified by the daily census of patients and employees.

The per capita meal cost figure has been disregarded because it is subject to misinterpretation, and because it does not yield to the scoring system as readily as does the meal cost.

Except in large hospitals, with accounts on an accrual basis and complete inventory systems, monthly figures tend to be unreliable.

7. Waste: So much has been written concerning the elimination of waste in food preparation that any remarks about it often seem threadbare and annoying. Yet waste must be kept down to the minimum. This involves (a) economical, careful purchasing of food best suited to the needs of the patient and the pocketbook of the institution; (b) preparation of correct quantities; (c) serving of suitable portions; (d) watching and checking the amount of garbage; (e) preventing unnecessary breakage of dishes or equipment; (f) intelligent hiring and handling of personnel so as to secure a minimum pay roll for the work performed; (g) suitable checks to make sure food or equipment are not being stolen or otherwise misappropriated; and (h) other waste preventive measures well known to dietitians and hospital executives.

No attempt is made to give each one of these seven or eight individual points a specific rating. They are mentioned because they make more concrete the question of whether proper steps are being taken to minimize waste. After reviewing them honestly, it should not be difficult to decide upon an approximately correct rating in this respect; that is, whether a department is entitled to, say, six, eight or ten points.

8. Complaints: Like poverty, these are always with us. Yet they should not be serious or excessive in number. The dietary department should function smoothly and not be a source of worry to the superintendent and other executives. Generally speaking, there should not be more than one justified complaint for each 100 meals served, including criticisms addressed to waitresses, maids, nurses and dietitians. Naturally, there must be a distinction between justified and unjustified complaints, with a disregard of the latter.

9. Teaching: Most hospitals teach dietetics, in greater or less degree. The student nurse, in particular, must be given an outline of the relation of food to illness and health, and must be instructed in the proper preparation of food. The rating should be based upon two factors, first, the excellence of the teaching and, second, the completeness with which the teaching field is covered.

How shall we judge the teaching? By the product, taken as a whole. How genuinely capable is the graduate dietitian? If she has only theoretical knowledge without practical ability to manage a dietary department so that it may be properly given a "good" rating, she is more of a liability than an asset and is not worthy of a self-respecting school. There is need in many places to revise and amplify the teaching now given student dietitians, with particular emphasis upon results. The training (for training it should be, as well as study) should fit students to take the "professional standing" previously mentioned, and really to help hospitals.

10. Progress: Does the dietary department move forward, or remain stationary from year to year? Is it still doing "the same old things in the same old way?" Has any new and improved equipment been purchased? Are there any plans for the future? Has the dietitian attended county, state or national conventions? Is the current literature concerning hospital dietetics provided for the dietitian and is it read and digested? The answers to these questions will provide the rating under this heading.

Now, for the sake of brevity and clarity, let us rate a typical dietary department in a modern hospital.

Yard Sticks and Actual Measurements

	Score
1. <i>Cleanliness</i> : Equipment 90 per cent clean; floors 100 per cent clean; some dirt in dishwashing room; two out of fourteen refrigerators not up to standard; otherwise the department passes a rigid sanitary inspection; a standard physical examination of all dietary employees.....	8
2. <i>Quality of Food</i> : Raw food of high quality; cooking good; chefs have full grasp of job; nine out of ten patients and employees interviewed say quality of meals is good but exhibit no enthusiasm; inspection shows appreciable loss of flavor due to slow service; menus well balanced but not diversified	7
3. <i>Quality of Service</i> : Patients' trays attractive; nurses well served, but dining room dark and gloomy; clerks' dining room short of waitress and disorderly, with used dishes on table; incomplete	

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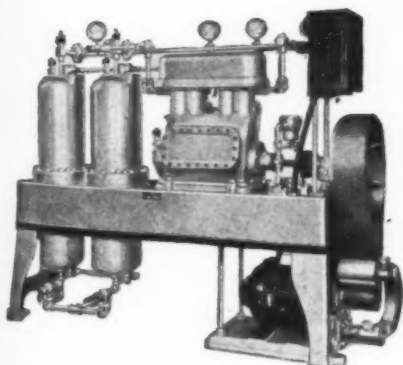
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Superintendent
Hospital
Street City and State

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- supervision of service to employees; help's dining room neglected 5
4. *Post-Stove Time*: Food reaches patients or employees about forty-five minutes after being cooked 6
5. *Completeness of Task*: All functions well performed 10
6. *Costs*: During the three months ending November 30, nearly 135,000 meals were served at an average cost of 29.1 cents, in comparison with a budget cost of 27 cents; all three elements of cost were in excess of standard..... 12
7. *Waste*: Very little attention paid to this problem; no record of any causes of waste being eliminated during last three months; garbage not watched for this feature; direct evidence of moderate waste, which might ordinarily be considered as normal; breakage of dishes or equipment is reasonable; food watched and checked to prevent loss; portions are proper; careful purchasing..... 5
8. *Complaints*: Normal, except among help and clerks 4
9. *Teaching*: Well done 10
10. *Progress*: Reasonable, considering physical limitations; partial attendance at conventions; subscription one magazine; no new equipment in past year; dietitian apparently wants to do better work..... 4
-
- Total score 71

The result indicates a fair department, though surprise would undoubtedly be expressed at such a rating.

The yardsticks can be applied as often as desired. They may be used with particular advantage as an annual dietetic audit, revealing the standing at the close of each year, in the same manner as accountants go over the books. The first audit can be made at any time, and should preferably be repeated at the close of each year, so as to gauge accurately both the relative standing and the progress made.

The Dietitian's Opportunities Are Many

A recent issue of the *Journal of the American Dietetic Association* has the following observations by M. Faith McAuley, assistant professor, institution economics, University of Chicago, Chicago:

The work of the dietitian gives an opportunity for social service of rarely high order. The field is relatively new, and like many others is awaiting adjustments with closely allied fields. The work of the administrative dietitian is increasing in importance and scope. The earlier accent on the corrective diet is now paralleled by that placed upon the normal diet, just as preventive medicine is now supplementing corrective treatment.

The normal diet kitchen is rapidly assuming a new and important role in the work of the hospital. The administration of the food unit involves problems in organization that include both the building and the personnel. The various parts of the unit must be effectively related and the working force properly placed to insure the best results. Equipment problems are present, in which materials, construction, and placement are involved and must be considered. The engineering aspect of equipment also has a way of pushing to the front, often unexpectedly, and announcing its importance in a most disconcerting fashion.

The administration of an institution kitchen equipped with modern machinery calls for information concerning materials, construction, installation, operation, and care. The dietitian needs to draw heavily, too, on psychology, sociology and ethics, in meeting the many management problems involved in the direction and instruction of workers. The care of the building, of general supplies and of food, gives opportunity for the use of much applied science. The work of teaching student nurses is also frequently a part of the work of the dietitian, and here pedagogical skill is called for.

Tomato Juice at a Health Resort

Tomato juice is a popular beverage at French Lick Springs, Ind., a well known health resort. According to the manager, R. J. Tompkins, the guests consume over four thousand gallons of specially prepared tomato juice each year. In commenting on this, Mr. Tompkins says: "In late years physicians and dietitians have demonstrated that the juice of the tomato contains many beneficial elements, the chief of which are the three vitamins, A, B and C, and the recently discovered vitamin E, which assists the red blood cells in absorbing iron from the blood. These are necessary for nourishing and strengthening the entire human organism."

Tomato juice may be served plain or with a pungent seasoning in it. One method of preparing it is to pour the juice out of the can and press the pulp through a sieve. Chill and season with salt and pepper. Add lemon juice, tabasco, or Worcestershire sauce, if desired or any other seasoning.

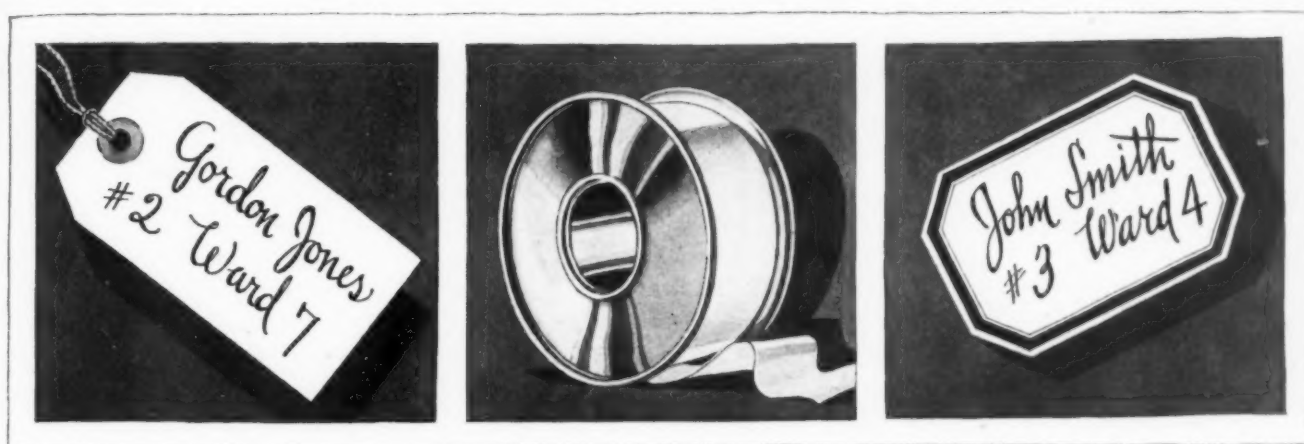
The use of canned tomato juice has been growing ever since the discovery that the canning process acts as a preservative of vitamin C, which not only prevents scurvy but is necessary for growth and good health. Much of this conservation is due to the acid content of the tomato itself. In addition to vitamin C, tomatoes rank with lettuce and green string beans as a source of vitamins A and B.

Increasing popularity of the tomato as a source of vitamins is due to the fact that it can be obtained all the year around at a comparatively stable price, and because the labor of preparing it for use is smaller than for almost any other source of the vitamins, a matter of importance in the hospital or health resort.

Protecting the Flour Supply

Hospitals that carry any considerable quantity of flour in storage should exercise great care to see that it is properly protected against dampness. A good plan is to pile the surplus stock of flour on inch boards, over concrete, but never directly on the concrete. Another thing to guard against is excess heat or humidity which is likely to cause caking or other deterioration. One of the best preventives of this is a free circulation of air which strongly counteracts extreme humidity or heat.

As flour rapidly absorbs odors, care should be taken not to use tarred paper or other strongly smelling materials near the place where flour is stored. Care should also be exercised in the use of disinfectants on account of the effect they may have on the flour, either through their odor or through damaging the flour in other ways, as in the case of sulphur dioxide, which destroys the gluten in the flour.



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Simplifying Record Keeping in a Teaching Hospital

By FLORENCE G. BABCOCK

Record Librarian, University Hospital, Ann Arbor, Mich.

DR. George Gray Ward in an article on hospital standardization says: "In these days of large and complex organizations it is not possible for one man to stand alone by individual achievement and to bear the burden without the help of those around him. He must have that type of loyalty and of harmonious cooperation in which each member of the staff performs the function for which he is best suited without the loss of his individuality and initiative, although his efforts are controlled and coordinated for the best interests of the institution."

The opening of the new University Hospital, Ann Arbor, Mich., in July, 1925, gave the record department an opportunity to achieve such cooperation by becoming a centralized unit. This means first that one registration number is used for each patient for all time, including all readmissions. Second, all the records from the out-patient department, as well as those of the in-patients or house cases, are brought together under one head. Thus the entire record of an individual is kept together regardless of how many times he may be admitted. This has automatically done away with the time-worn bound volume.

All sheets and forms both for out-patient and in-patient records are of uniform size, eight and one-half by eleven inches, with the exception of the x-ray report and certain laboratory sheets, which are half size.

The registration sheet, on which all identifying data concerning the patient are written, becomes the initial sheet of the record, with sufficient space provided for final diagnosis and operations for several admissions. The patient takes this sheet to the clinic, where his out-patient department history and examination are made and recorded. At this point the record is placed on a light weight manila backer, fastened at the top by means of two prongs, one and one-half inches in length, with a metal bar to bind the record firmly in place.

A great advantage of this system is the financial saving, not only of commodities such as folders, backers and cards, needed for the admitting of a patient, but in the time saved in the services of physicians, clerks and others, who handle the routine of a new patient, for a patient is new but once, instead of many times, as when he is readmitted each time with a new number.

The practicability of a unit record system depends

largely upon the geographical location of the department. At the University Hospital the central record department, including the file room, the cataloguing room and the dictaphone room, is centrally located on the diagnostic floor where all the out-patient clinics are conducted. The use of a carrier system with a station at each clinic has proved tremendously time-saving, since this one floor covers 33,200 square feet of space, and 10,000 clinic visits are made on the average each month. The cost of this system, installed for nine stations at the time of the construction of the building, was \$7,577.

But it is not only the patient returning to the hospital for further treatment who is benefited by this coordination of the out-patient and in-patient records. The value of the unit system for a teaching hospital and for scientific research cannot be overestimated. The fact that since its installation about 25,000 cases have been used for study purposes indicates its usefulness.

Admitting the Patient

An outline of the steps taken by a patient in the admitting procedure will bring out clearly the working of this system. A patient coming to the hospital for the first time stops at the information desk. There he is asked if he has ever been treated at the hospital. If not, he is given blanks and directed to the registration desk where they are filled in. A patient with a letter from a referring physician is registered and sent at once to the service requested. If he has no letter he goes to the house physician's office where after a preliminary examination he is assigned to a clinic. This out-patient examination is made whether the patient is to be admitted to the house or to be treated in the out-patient department. From this out-patient group, admissions to the hospital average fifty patients a day. A separate report is kept of admissions, transfers and discharges.

At the clinic the patient's name and registration number are entered by a clinic clerk in a daily registry. The clerk also notes besides the patient's name "N. P." (new patient); "N. R." (new or re-registration, as all patients are re-registered one year from date of their previous registration, still retaining their original registration number); "N. C." (new to clinic, meaning a refer or transfer); "O. P." for old patient or return visit. The

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clerks use these daily registries to compile the monthly statistical reports sent to the record department. From these reports the statistics for the entire out-patient service during the month are compiled. The fact that a patient is re-registered each year enables us to count each individual but once during the year.

Returning to the course of the patient who was recorded by the clinic clerks, after registration the patient's history is taken and he is given a physical examination. He is then instructed as to x-ray, basal metabolisms, electrocardiogram or any other special examinations indicated, and may also be referred to other clinics for an opinion as to other conditions requiring treatment. On the completion of the out-patient examination and the return of the various reports of tests and opinions the patient is either told to continue treatment in the out-patient department or admitted to the hospital. If the latter, he is given a bed slip to take up to the admitting office to make arrangements for admission. Whether his admission is immediate or postponed, his examinations and tests have been completed and he is ready for an operation, if that is indicated.

How Hospital Records Are Compiled

When he arrives the admitting office sends his bed slip to the record department as a notification that the patient is in the house. His record, which has been kept in the clinic while he was under observation, is immediately sent by the record clerk to the ward where the necessary material accumulates to complete it. This includes, in some instances, a supplemented history, in more detail, progress notes and a full account of the operation. This is dictated to a stenographer while the patient is still in the operating room or immediately afterwards. Finally a case summary, a brief resumé of the case, including a discharge note, is dictated to the dictaphone within twenty-four hours after the discharge of the patient. This case summary is made in duplicate and one copy is sent to the referring physician, as each referring physician receives a report of the findings on his patient while he was in the hospital. In some cases the referring physician has a preoperative letter and on some services a special letter instead of the usual case summary.

All histories, physicals, case summaries and some notes are dictated to the dictaphone. Six dictaphone operators and about eighteen dictating machines are in use, two or three machines to each transcriber. Within twenty-four hours after the discharge of the patient the record is sent to the clinical stenographer on each service, who in turn receives each day, from the main office via the record room, a discharge slip for each patient on the service. Every discharge slip must match a corresponding record, thus indicating when all records are returned to file. The stenographer is responsible for the proper arrangement and completion of the record, noting that the properly authorized physician or surgeon has entered on the registration sheet the complete and final diagnosis and operation, including all consultants' diagnoses as made on the refer sheets, providing a positive diagnosis was made. With the signature of the doctor as his final word, the clinical stenographer puts the date and her O. K. on the back of the record and lists all records leaving her department. They are delivered to the cataloguing department to be further inspected and catalogued. Her book is checked and all records received in the cataloguing room are signed for by them.

Frequently the patient is only sufficiently improved to be transferred to one of the convalescent hospitals and is

not ready to be discharged home. In this case his record does not leave the hospital to go with him, but a supplementary sheet and a copy of the case summary go with him. The supplementary note sheet indicates why the patient is being transferred, his probable length of stay at the convalescent hospital and what his treatment should be while there. He may be requested to return to the out-patient clinic for dressings or physiotherapy, bake and massage, but whatever the case may be his progress notes are recorded on the supplementary sheet and when he is finally discharged this sheet is incorporated in his record.

A complete name file is kept in the file room and the records are all filed numerically. The "elimination system" of filing name cards is in use. This not only shortens the time for filing and finding cards but aids greatly in location of foreign names and names with an alias under different spelling. A request was once made by a social agency for information about Therese and Luigi Mulite alias Mollita, Molita, Melito, Malito, Militi. According to the elimination system there was but one spelling to catch any of the above six spellings.

An expedient method of locating at any time any one of the 1275 patients in the main hospital, or in one of the convalescent hospitals, is the photostat copy of the alphabetical card file. Several such copies are made each night after the cards have been checked with the midnight census, so that each department needing such a list may have one.

Cataloguing or indexing of the cases according to diagnosis and operation is the part of the work that produces the material for two of the most important functions of the hospital—the educational and teaching part and the advancement of science through clinical research. Much of this work is done through the study of records, individually and collectively, therefore one of the first requisites is speed in collecting a group of cases. The unit system provides an efficient and expedient method of collecting such a group of study cases as, for example: A group of twenty-five cases of diabetes with two admissions each would mean drawing from the file fifty records instead of twenty-five, if each admission were filed separately, and this proportion becomes several times increased with a diagnosis of syphilis, when one patient has anywhere from one to thirty admissions in one year.

How Unit System Operates

Another requisite is sufficient data on the diagnosis cards to guide in the selection of the group. The unit system calls for a unit diagnosis index, which combines in one index the out-patient and in-patient diagnoses. This may be done satisfactorily when a thorough examination and study is made of the case in the out-patient department. The diagnosis is not a "snap judgment," as frequently happens in out-patient departments. The so-called complication file is also combined in the unit index by the use of black and red ink, using black ink for the main diagnosis and red ink for an associated diagnosis.

On a card of osteomyelitis, if the case is indexed in black ink it means osteomyelitis was the main or primary diagnosis, if in red ink it means that osteomyelitis was an associated diagnosis and the main diagnosis is mentioned in the first column. This gives the picture of osteomyelitis associated with a main diagnosis of, for instance, empyema of pleura, thus grouping for study and statistics all cases of osteomyelitis with proper qualifying terms plus a combination of terms, such as osteomyelitis and empyema of pleura and osteomyelitis and gunshot wound. Many hospitals use only a history



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number on the diagnosis card, but from experience I have found that the effort expended and the time taken to enter on the card the patient's name, age and qualifying terms, with the diagnosis bring a more gratifying result and prove the old adage that the "longest way round is the shortest way home."

Two instances of the above may be cited as follows: The first was a request to locate a boy who came to the hospital in the spring of last year. He had osteomyelitis and all the details of his injury could be remembered but not his name. The fact that the name was a long Polish name was quite distinct in the mind of the doctor, as was the approximate age of the boy. The problem was thus to locate the boy out of 400 other cases of osteomyelitis. It would have taken considerably over an hour of tedious hunting to look at the histories of these 400 cases, if there had been only the registration number on the card, but since the names of thirty cases were given on each 5- by 8-inch card, fifteen on each side, it took only about one minute and a half for the doctor to glance down several cards and find the name. Thus it was necessary to take but one record from the file, instead of 400.

Another instance of a time-saving versus time-consuming problem was a request for all cases for the past ten years of a rare condition. The only information desired was the sex of the patient, whether this case were operative or nonoperative and the year. In actual time it took about an hour to look up ten old cases taken from cards, with only the registration number given, whereas the same number of cases were found on the cards themselves with more complete data in less than three minutes.

Operations are classified in the same way as the diagnoses, again aiming to answer questions before they are asked. Typing the name of the operator on the card beside the name of the patient enables a surgeon to pick out certain cases or groups of any operation he has done without the long process of going through page after page of an operating book.

Cost of Operating Unit System

There are forty-four persons employed in the record department, distributed as follows: The record librarian in charge; eight record clerks; four cataloguers; fourteen clinical stenographers; six dictaphone operators; eight clinic clerks; one typist; two messengers.

There were 123,043 clinic visits made during the period July 1, 1926, to July 1, 1927; patients spent 367,424 days in the hospital; 11,067 individuals were treated in the out-patient department but did not enter the hospital; 18,008 persons were hospitalized. Many of these patients were treated in the out-patient department either before or after their period of hospitalization, or frequently both before and after.

The cost of running the record department for these 29,000 patients, including correspondence about them, was \$30,000, or practically one dollar per year per patient.

The central record department is much like a river with many tributaries. The details of these branches have not been discussed in this article, as much is still in embryo and more is developing through a process of education. This, of necessity, takes time, but the advantages to both patient and staff of the unit system and the improvement shown over the old method, when each service functioned individually and no complete picture of the patient's experience was possible, have become evident to everyone in the organization. Their cooperation has made the road much easier to travel, and is an inspiration to strive in every way to make the record department an effective arm of the administration.

How Shall Research Be Promoted in the Mental Hospital?

The lack of research workers in the field of psychiatry and the desirability of a research department in the mental hospital is the subject of an editorial in the *Medical Journal and Record*, in which the following paragraphs occur:

It is a regrettable fact that, with mental hospitals literally teeming with research material and psychiatric clinics offering unparalleled opportunities for the study of psychiatric problems from the social point of view, there are so few research workers in the field. Not that the research spirit is lacking in the psychiatrist, far from it. The young physician just beginning his work in psychiatry is usually fired with the enthusiasm for research inculcated in the medical school and fostered by the novelty of his specialty and he should be given every possible opportunity to develop along this line.

Too Few Psychiatrists

It is safe to say that in large public hospitals for mental disease there are never enough psychiatrists to keep the routine work up to par, unless they spend all their time with their noses to the grindstone. If they are moved to do research work, it must be done after the regular day's work is over. But the fire of enthusiasm, though it may burn brightly in the morning, has a way of fading to a feeble flicker and passing ignominiously out by the time the last ward rounds are made for the day.

Sometimes the intern's ambition outlives his internship and follows him through his various promotions. With the reading that he has managed to squeeze into odd moments, he feels prepared to utilize his, theoretically, increased leisure in the coveted research. Aside from the fact that patients are tired and uncooperative, nurses are too busy to be helpful and wards are full of the end-of-the-day commotion, the investigator himself is in no fit mood to approach patients or problems in an unprejudiced, clear thinking frame of mind.

Spare time research is better than no research at all, but it is unfortunate that conditions should necessitate it. The hospital expects the pathologists and bacteriologists and other laboratory workers to work out their particular problems as a legitimate part of their regular work. Perhaps the hospital expects the psychiatrist to do the same, but the psychiatrist's daily work is so closely bound up with the aches and pains, both mental and physical, of the sick people intrusted to his care that their needs have to be attended to first, and when that is done, the day is gone.

Where the Solution Lies

Perhaps the solution lies in the establishment of a research department in the mental hospital, a department composed of experienced investigators who devote their time exclusively to the pursuit of psychiatric research, with the cooperation of all other hospital departments. Perhaps, on the other hand, a certain number of hours of research each week might be required of each member of the staff, the hours to be assigned and relief from routine work provided. A combination of these two arrangements might permit the psychiatrists who have real interest in research, to work a certain portion of each day with the research department, leaving their less interested colleagues to take their calls and make their rounds for them.



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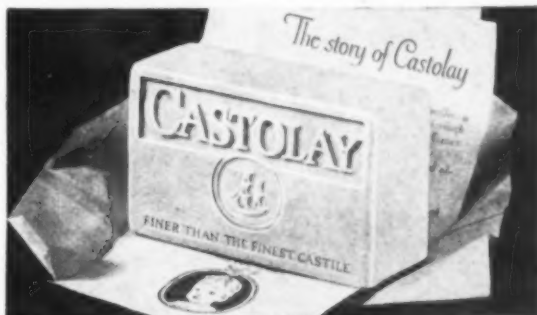
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Conducted by C. W. MUNGER, M.D., Director,
Grasslands Hospital, Valhalla, N. Y.

How the Motion Picture Fits Into the Hospital Scheme

By ELIZABETH RICHEY DESSEZ

New York

THE motion picture in the modern hospital may be used for two purposes: as entertainment for the patients and the staff of the hospital and as an aid in instructing probationers, orderlies and other employees of the hospital in efficient methods of performing their duties.

While plenty of pictures are available for entertainment purposes, pictures for aid in hospital work are practically non-existent. It is quite possible that within a short time such pictures will be made and distributed to the hospitals of the country in a manner similar to a theatrical circuit.

Physicians and nurses know that the most trying time both for patients and nurses is the convalescent period. This is the period when the sickness and suffering are over but when the patient is forced to lie inactive day after day waiting for Nature to restore him to health and strength. The cheerful and courageous patience which men and women show when in pain, then gives place to a nervous irritation that manifests itself in many ways. The patient is grouchy; he complains of the food and of the service, and chafes against the wise restraint that keeps him in bed. Reading soon palls; letter writing requires too much effort; visitors cannot remain by the bedside longer than for a brief visit. This irritability on the part of the patient becomes transmitted to the nurse and her nerves are put under an unnecessary strain.

Keeps the Patients Happy

Doctors know that good humor is a great aid in helping sick people along the road to health and strength and they are continually urging the nurses to keep their charges happy. The motion picture is an excellent medium for doing this.

All the motion picture companies have pictures that they will gladly rent to hospitals or sanitariums. These are of high caliber and are the same pictures that are shown in the theaters. At the same time the motion picture companies set a low rental on these films, charging only enough to cover the cost of shipping the films and inspecting them upon their return, plus a small margin of profit. The companies will gladly supply,

upon request, catalogues or lists of films that are available to hospitals and similar institutions at a moderate charge.

Portable projectors are available and these are ideal for hospital use. They can be set on a table in the middle of the ward, and can be attached to an ordinary electric light socket. Since many hospitals have plain white walls in the wards, no screen is necessary. The mechanics of showing the pictures is reduced to a minimum. The projector can be easily carried from ward to ward so that one picture may be shown to all the convalescent wards in one day.

Throw the Picture on the Ceiling

In the Walter Reed General Hospital, Washington, D. C., and in other hospitals where the patients are compelled to lie flat on their backs, the projector has been turned on its back and the picture thrown on the ceiling.

The pictures have an exhilarating effect upon the patients and this form of recreation is less tiring than reading, writing or playing games. They offer a topic for conversation, too, and it is far healthier for two patients to discuss the relative merits of one motion picture star over another, than it is for them to talk continually of their various ailments—a form of indoor sport to which inmates of hospitals are unusually prone.

Children in particular can be benefited by the showing of pictures. Their patience is limited, and once their pain is relieved, their energy returns quickly and it is hard to get them to rest. Since children like the motion picture, the hospital may thus be made for them not a dreary prison of enforced inactivity but a long-to-be-remembered place where they saw some wonderful "movies." Great care, however, should be exercised in the selection of pictures so that they will not disturb or excite patients.

The programs shown in hospitals should be varied but a news reel should be a part of every program. It will keep the patients informed on what is going on in the outer world and will give them a feeling of participation in everyday life. Provided none of the patients are recuperating from operations or wounds of any kind, comedies should be included in every program. Laughter is



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a great health giver as any doctor will testify, and the discomfort of the day can be dissolved by a little laughter before the patient goes to sleep.

If the patients are largely ignorant or are children, health films should be shown. There are many such films in existence showing the value of sanitation, teeth brushing and care of babies. By showing these pictures, the hospital is merely administering preventive medicine in a sugar-coated capsule.

Utilize Pictures With Educational Value

Pictures having educational value along other lines can also be made part of the programs. Historical, industrial, or geographical films exist in large numbers and are available not only from motion picture companies but from governmental bodies such as the United States Bureau of Mines, the Department of Agriculture, the Army and the Navy Departments and civic and municipal organizations. Large industrial companies also have pictures that they distribute. Such pictures can be used effectively in communities where a certain industry is predominant. For example, a hospital in Scranton, Pa., could show pictures from the Bureau of Mines, in Detroit an automobile film would be appropriate and a Pittsburgh hospital could screen film studies showing features of the steel industry.

As an alternative to such a program a regular feature picture might be shown. These pictures average about seven reels in length and take between an hour and a half and two hours to run. Such lengthy programs should be shown only to patients so nearly well that they would not be tired by them. These features should be selected with care; they should leave the audience happy and contented with the outcome of the picture. No harrowing, sad or sordid pictures should be used lest the patients become depressed. Light, whimsical, and humorous pictures are the best to show.

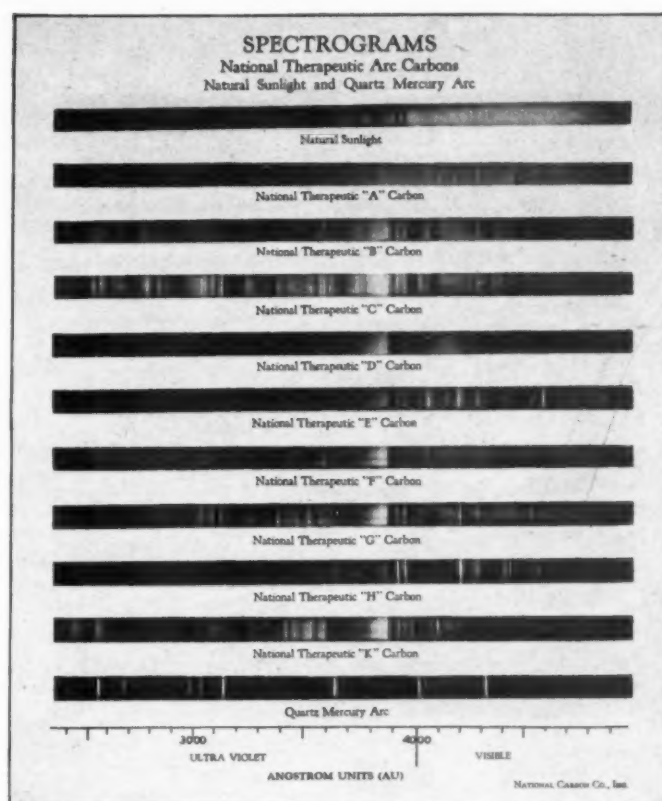
In the field of visual instruction for probationers, orderlies and other hospital employees much remains to be done. Pictures should be prepared showing how to make a bed, how to move a patient from one bed to another, how to make a bed when the patient cannot be moved, how to cleanse and sterilize surgical instruments, how to put on a dressing and how to remove one without causing unnecessary pain. These and many other details which the probationer has to learn can be taught effectively through the use of motion pictures. It would be a wise move for several hospitals to cooperate in the preparation of such educational films. By renting them to other institutions the production costs could be met, although the increase in efficiency resulting from such a plan would more than compensate for any expense to which the hospital might be put.

Entertain the Personnel

And the motion picture may be used as entertainment for the nurses, probationers, interns and other members of the hospital staff. The occupation of the trained nurse is an exacting one. The nurse deserves anything the hospital can do for her, and a regular motion picture show would do much to ease the strain under which she works. The other members of the staff could also attend such showings and profit from this form of relaxation.

The motion picture can make the hospital a more pleasant place for patients and staff alike. It can calm the restless, interest the apathetic and cheer up the downhearted. It is a cheap and practical solution of one of the hospital's greatest problems—how to keep the convalescent happy.

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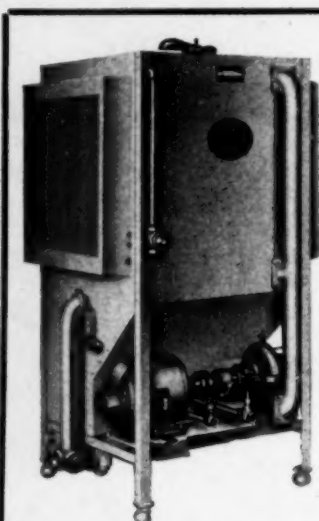
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types of National Therapeutic Carbons are available, covering the entire range of therapeutic light. Write for the booklet, "National Therapeutic Arc Carbons," sent to physicians and hospitals, free on request. This booklet gives complete details of the light from each type of carbon, with spectrograms. National Therapeutic Carbons are sold by arc-lamp makers and physicians' supply houses.

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Artificial Radium Rays—A New Tool for the Scientist

Artificial rays of radium, in quantities that could be obtained only from a ton of this valuable element, worth fifty-six billion dollars at present prices, will soon be produced in the laboratory, according to a statement in *Science News*, credited to Dr. William D. Coolidge, of the General Electric Company, Schenectady, N. Y., inventor of the x-ray tube now in general use. Dr. Coolidge revealed for the first time details of a new form of his cathode ray tube, which, by a method of cascading, he has already operated at 900,000 volts, three times as many as previously achieved.

Radium gives off three kinds of rays: alpha rays, or rapidly moving atoms of helium; beta rays, or speeding electrons—the "atoms" of electricity—and gamma rays, similar to x-rays. It has not been possible to successfully imitate radium radiation because sufficient electrical power could not be put into the generating apparatus.

Dr. Coolidge's latest invention will make it possible to increase the voltages applicable to x-ray tubes generating gamma rays, and it will also enhance the power of the cathode ray tubes and speed up electrons that correspond to beta rays. In fact, it may be possible in time to surpass the power of radium and provide a new tool for the scientist, who now uses radium medically and industrially with telling effect.

What the Apparatus Can Do

Speaking before the American Institute of Electrical Engineers, Dr. Coolidge indicated what the apparatus can do:

"This opens a vista of alluring scientific possibilities. It has tantalized us for years to think that we couldn't produce in the laboratory just as high speed electrons as the highest velocity beta rays of radium, and just as penetrating radiations as the shortest wave length gamma rays from radium. According to Sir Ernest Rutherford, we need only a little more than twice the voltage that we have already employed to produce x-rays as penetrating as the most penetrating gamma rays from radium, and three million volts to produce as high speed beta rays.

"The intensity factor would be tremendously in our favor, as with twelve milliamperes of current we would have as many high speed electrons coming from the tube as from a ton of radium. Another factor in our favor would be the control that we would have of the output. This would be quite different from our position with respect to radium, in which case no physical or chemical agency at our command in any way affects either the quality or the quantity of the output.

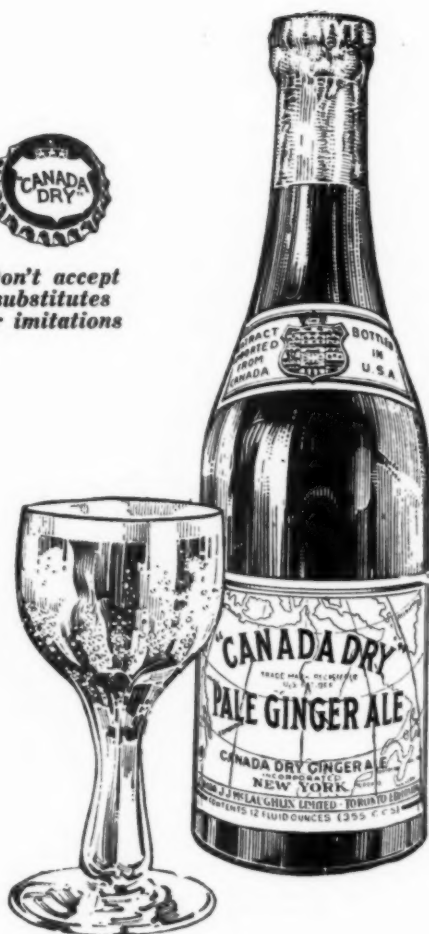
"What shall we do with the high speed articles obtainable from tubes operating at a potential difference of millions of volts? The lure, of course, lies in the fact that we can't answer the question, beyond saying that we shall experiment with them. They should eventually help us to further knowledge of the atomic nucleus and to further knowledge of radiation laws. It is, furthermore, not unlikely that therapeutic, chemical, bactericidal or other practical uses will develop."

Dr. Coolidge's original cathode ray is an evacuated bulb, with two long extensions. Through one end comes the cathode, which consists of a small electric lamp filament of tungsten. Such a filament, when lighted, gives off electrons, moving very slowly. Through the other projection from the bulb extends a long copper tube, the anode. When the filament is lighted, a copious stream of elec-

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CONVALESCENTS invariably like "Canada Dry." It is a mild, mellow ginger ale. It has a subtle gingery taste to it which whets dull appetites. It gives a pleasant change of regimen in the sick-room at meal time.

You can be certain that "Canada Dry" is pure. The highest quality of ingredients go into it. They are blended and balanced with the skill which comes of experience. Exact proportions of blending are established and hourly tests are made to make sure that those proportions never vary.

"Canada Dry" contains the finest quality of Jamaica ginger and other absolutely pure ingredients. "Canada Dry" does not contain capsicum (red pepper). That is why it does not bite the tongue or leave an unpleasant after-effect. Leading hospitals serve it and many physicians prescribe it.

You can find no purer ginger ale nor one which patients like so well.

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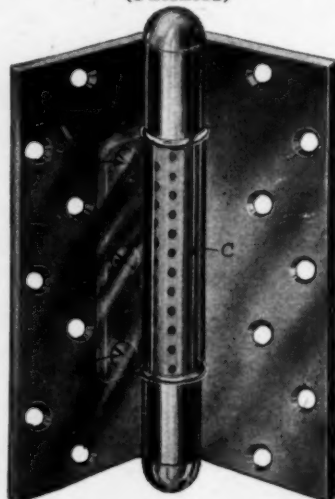
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trons is emitted. Then a high voltage, say 250,000, is applied to the tube. This powerful current speeds up the electrons so that they travel through the copper tube, and out to the open air through a thin nickel "window." A "cold cathode effect" prevents the use of more than about 250,000 volts in one tube.

The method now used by Dr. Coolidge to speed up the electrons still more is the very ingenious one of placing several tubes in tandem. The electrons, or cathode rays, in the first tube are furnished by the glowing filament. The end of the first tube takes the place of the cathode of the next, and the electrons from the first tube, already rapidly moving, are still further speeded up by the application of 250,000 volts in the second tube. The speeding stream is fed into a third tube, from which the rays emerge with a speed equivalent to that of the total voltage of the three tubes. With three tubes, Dr. Coolidge has obtained the effect of 900,000 volts, and much more can be used without serious difficulty.

When cathode rays strike a solid metal "target," x-rays are given off. Thus a similar arrangement could be used to produce the most powerful source of x-rays ever devised. To accomplish this the last bulb of the series would contain such a target, from which the x-rays would be emitted.

An Ice Crusher That Is Easily Operated

An ice crusher designed to save considerable time for nurses and kitchen employees has recently been introduced to the hospital field. This crusher is a small hand driven model, and has been found to be particularly adapted to utility rooms on each floor of the hospital for



the breaking of ice for ice bags, as well as in the kitchen where it is used to crush ice for the cooling of foods.

The machine is easily operated and requires no more strength than that of an average student nurse yet the time that is saved is considerable. It does not take up any undue amount of space and is attractively designed.

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These two films—the first of a proposed library of medical films, sponsored by the leading Medical Societies, are now ready—for rental or sale.

Copies available on 16 mm. film, for Kodaſcope projection, or on 35 mm. (standard width) film. All prints being on *Safety* base, fire hazard is eliminated. For particulars write:

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Consideration for their simple construction—exclusive features, and dependable service, Holtzer-Cabot Signaling Systems are specified by leading architects and engineers.

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A New Device for Reducing Noise

A device designed to absorb excess pressure shock on water lines, eliminating what is commonly termed water hammer and also all noises connected with toilet flushing, has recently been put on the market. The appliance has a special appeal to hospitals because it is one more means of reducing noise within the building, which is the aim of every competent superintendent.

This new device is not an air chamber but is fashioned on the principle of the rifle silencer. The rifle silencer does not provide a chamber for expansion but causes the gas waves resulting in sound waves to take a form in which the waves harmlessly and noiselessly spend themselves upon each other. The noise absorber for plumbing takes up and "damps out" the vibrations, the design being such as to cause the waves to cross and expend their energies upon each other, as well as upon a sensitive membrane within the appliance.

One of the features of the new noise reducer is that it can be completely and permanently adjusted and then covered up or plastered over and not given another thought during the lifetime of the plumbing itself. It is sturdily constructed of galvanized gray cast iron and high grade phosphor-bronze.

A Cheap Way to Remove Paint

By L. A. SEXTON, M.D.

Superintendent, Hartford Hospital, Hartford, Conn.

The high cost of paint removers, and the painfully slow process of brushing on the remover and scraping off the loosened paint caused us a year or two ago to analyze several of the commercial removers. The results of these analyses were illuminating, particularly as to the cost and nature of the ingredients.

The retail price of the several commercial removers is about \$2.50 per gallon. About a gallon is required to remove the paint from one hospital bed that has been painted year after year until it has on it six or eight coats of paint. If the paint is not baked on too thick, one man of an exceptional type can clean and rub down two beds daily. This makes the process not only expensive but slow.

After experimenting with paint removers until we had a satisfactory formula, we built three vats, 4'x6' 10" in size and 15" deep, of two-inch cypress boards. The two end vats that were to be used for the remover were lined with sheet lead. The one in the center used for washing the beds after the paint is removed is supplied with a hot and cold water hose connection. These are kept filled with the remover, and the beds, or other hospital furniture to be cleaned, are dropped into the solution and allowed to remain until the paint is sufficiently loosened to be removed quickly and easily with a heavy fiber or wire brush. The pieces of furniture are then brought up with iron hooks, hosed off and cleaned, dried and rubbed down, at which time they are ready for another coat of paint or lacquer.

One man can clean and rub down forty beds daily by this process, and one man who is clever at spraying can do about twenty-five beds per day with a sufficient number of coats to complete the job.

The different types of spraying outfits and the various makes of lacquer have been described so often in recent years that it is not necessary to discuss either of these at this time.

The Silver Service for the FIFTH AVENUE HOSPITAL



The flat tops of the hollowware make easy and convenient the stacking of full trays. The flat-topped pots can be easily stacked.



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Avail yourself of our experience in designing and manufacturing pins of unusual character for hospitals in all parts of the country.

Class Rings—Diplomas

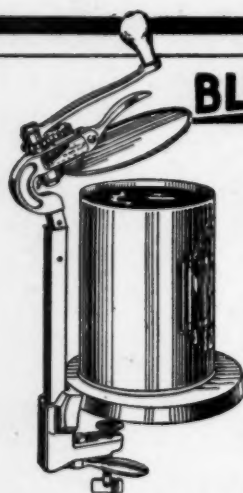
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The formula that we worked out and have found entirely satisfactory is as follows: sodium hydroxid, fifty pounds; benzol, one gallon, five pints; water, eighty gallons.

Dissolve the sodium hydroxid in the water and allow the solution to cool, then add the benzol.

The cost of this solution is about five and a half cents per gallon. This should remove the paint, no matter how thick, in about ten to twelve minutes. When the solution weakens and requires more than twenty minutes to remove the paint, we add a sufficient amount of the ingredients to bring it back to its original strength.

The above formula is for metal furniture only. To remove the paint from walls or wooden furniture the proportions must be modified by increasing the benzol and reducing the sodium hydroxid to meet the requirements.

Surgical Gauze Schedule to Be Simplified

On February 15 a general conference on surgical gauze was held in New York under the auspices of the Division of Simplified Practice of the U. S. Department of Commerce, Washington, D. C., when constructive proposals for the benefit of manufacturers, distributors and consumers of surgical gauze were considered.

The proposals were based on a careful study of conditions and requirements made by a simplification committee and an executive committee appointed at a meeting held on March 29, 1927. This meeting was the first of a series of conferences between manufacturers and representatives of some of the larger consumers of surgical gauze and was called to consider the practicability of eliminating unnecessary variations in widths and lengths of that commodity.

How Project Developed

In opening the conference the representative of the Department of Commerce briefly described the development of the project and the part therein of the Division of Simplified Practice.

The agenda was then presented by H. R. Lane, chairman of the industry's executive committee. He explained to the conferees that the desire of the manufacturers was to establish a simplified line of surgical gauze which would properly take care of normal requirements as disclosed by the committee's survey.

The proposed schedule was then considered in detail. In connection with gauze in 100-yard bolts, it was felt by some that the twenty-two by eighteen construction might be eliminated. Reference to the survey report, however, showed that the demand for this item warranted its retention for the present. The conferees finally agreed that the item remain in the accepted list with the understanding that its elimination be given special consideration at the first revision meeting of the standing committee.

It was the opinion of the conference that other constructions for gauze in 100-yard bolts could profitably be eliminated and the standing committee was charged with making an investigation to determine which constructions could best be dispensed with at the time of the first revision conference.

When considering bandage rolls, one of the conferees pointed out that the thirty-six by thirty-two and forty by thirty-six constructions had been retained in spite of the fact that they were eliminated from gauze in 100-yard

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Efficient.—Hycol has a carbolic acid coefficient of 20 (original Rideal-Walker test using typhoid germs)—i.e., it is 20 times more powerful as a disinfectant than pure carbolic acid.

Economical.—Because of its great germicidal strength, Hycol will make much more disinfectant solution than will the ordinary disinfectants on the market—at least 6 times more than will Solution Cresol Compound of the U. S. P. and disinfectants of similar type. Notwithstanding its strength, the price per gallon of Hycol is low.

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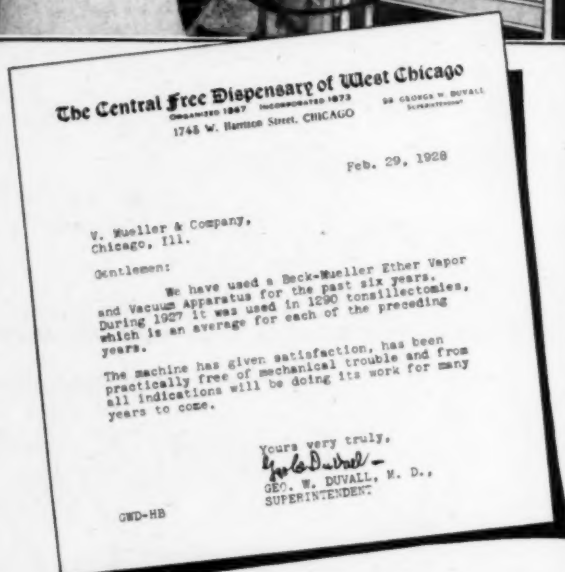
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Above is shown an actual photograph taken in an operating room of Central Free Dispensary, Chicago. The BECK-MUELLER ETHER VAPOR and VACUUM APPARATUS in the picture is the one mentioned in the brief but convincing message reproduced.

AT WORK in 1290 operations a year, for six years! And "from all indications" this faithful machine will be doing its job of supplying ether vapor and aspirating the operative field "for many years to come."

Isn't there a place for this apparatus
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Manufactured by

V. Mueller & Co.

Ogden Ave., Van Buren & Honore Sts. CHICAGO

bolts. It was finally decided to approve this elimination leaving these particular constructions of bandage rolls as special items to be furnished only on demand.

The section of the recommendation having to do with crinoline was approved without change.

The schedule for bandages was adopted without change after some discussion as to the necessity for retaining the two and one-half inch width. The standing committee was directed to give special consideration to the possibility of dropping the two and one-half inch width at the next revision conference.

The schedule for package goods was approved after eliminating the five-yard packages in the twenty by sixteen construction.

Manufacturers and users of the items suggested for elimination at the first revision conference are requested to cooperate with the standing committee, either by writing to the chairman of the standing committee or by supplying information requested by the committee when a survey is made to determine the need for these items.

The conference in adopting the agenda, as modified, was guided to some extent by the approval and indications of support received by letter from hospitals, organizations, and individuals not represented at the meeting.

The standing committee will convene at the end of the first year of this recommendation for the purpose of considering the question of revision in accordance with instructions of the conference and to act on suggestions offered during the first year of operation of the recommendation.

The action of the conference resulted in the elimination of the following items:

Surgical Gauze: 15 constructions reduced to 7.

Crinoline: 5 constructions reduced to 3.

Bandage Rolls: 10 constructions reduced to 3; 5- and 6-yard put-ups eliminated.

Bandages: 1 construction, 44 x 40 retained, no change; 5-yard put-ups eliminated; 8 widths reduced to 6.

Package Goods: 6 constructions reduced to 4 in 25-yard lengths; 4 constructions reduced to none in 10-yard lengths; 7 constructions reduced to 3 in 5-yard lengths; 6 constructions reduced to 3 in 1-yard lengths.

While these are substantial reductions, in variety, the conferees were of the opinion that other reductions could be effected and expressed the hope that all interests would cooperate with the standing committee in determining additional items that could be eliminated at the first revision conference.

In accordance with the unanimous action of the general conference held February 15, the Department of Commerce has drafted Simplified Practice Recommendation No. 86, Surgical Gauze, which submits for the approval of the industry a simplified schedule for the stock varieties of surgical gauze. The effective date for the recommendation is June 1, 1928.

When a Small Garbage Incinerator Is Needed

An incinerator that is both economical and efficient has recently been introduced to the hospitals of the country. This unit is compact yet large enough to incinerate large quantities of garbage and waste. It is constructed of cast iron which is immune from corrosion, and no steel or galvanized iron comes in contact with the fire.

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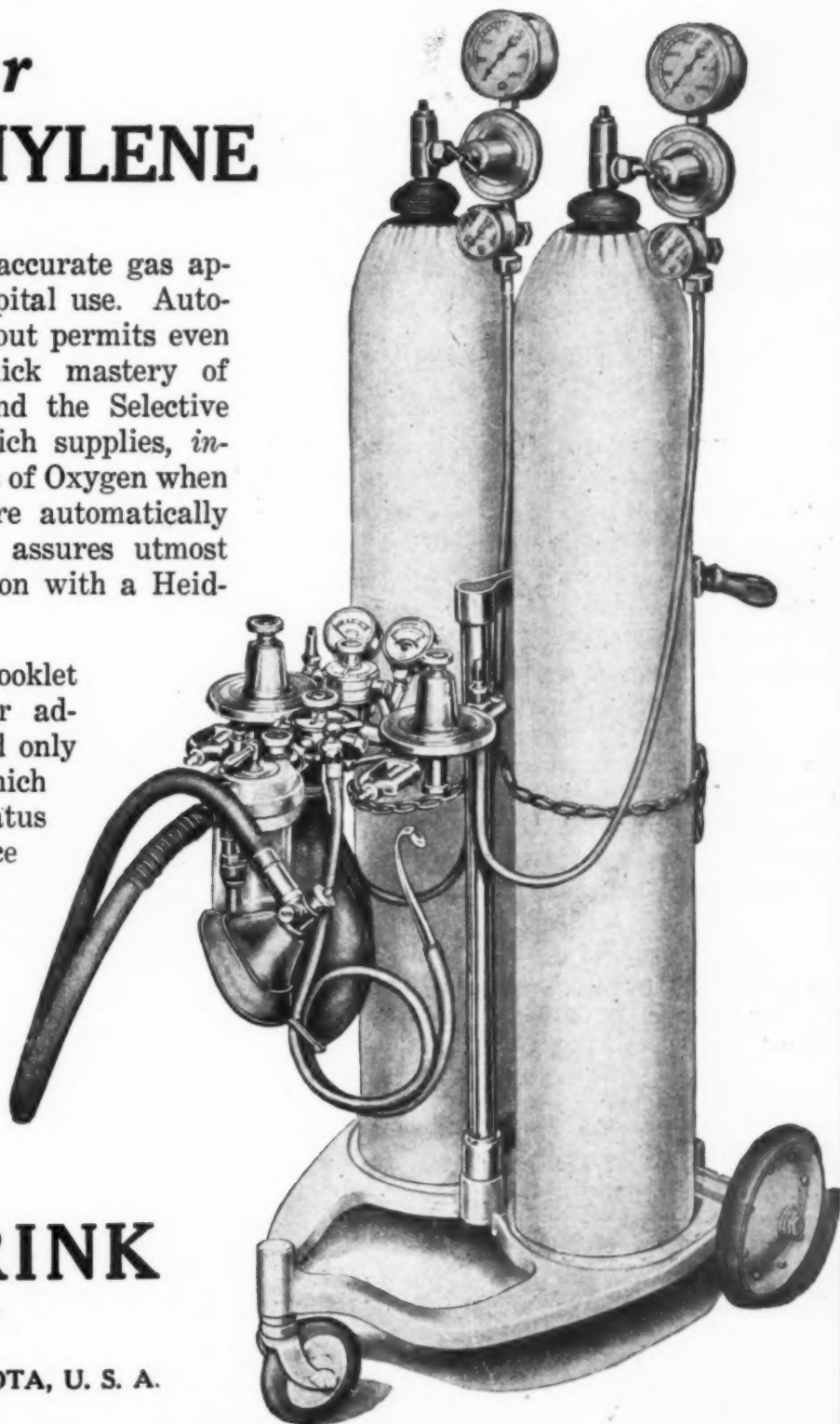
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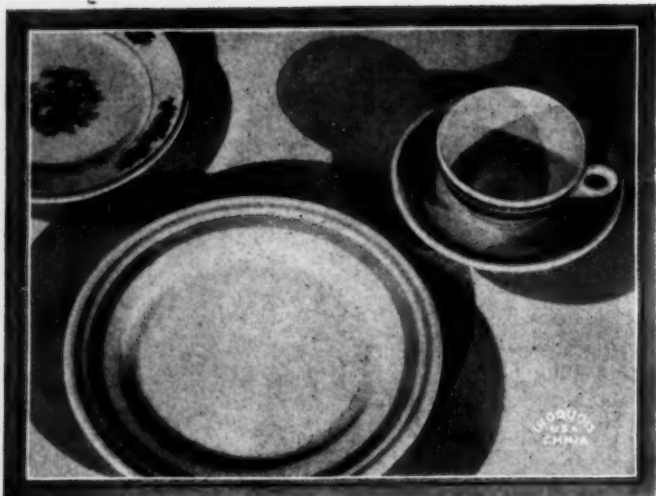
An interesting free booklet will tell you of other advanced features, found only on the Heidbrink, which have kept this apparatus foremost in the practice of expert anesthetists, and first in the choice of beginners.

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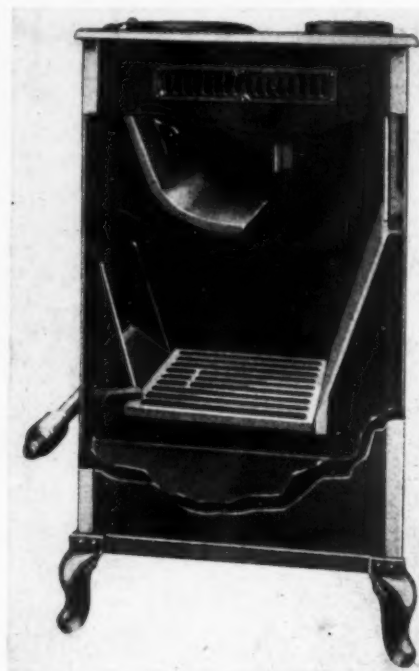
YOU may make your selection of design from a large number of appropriate stock patterns. Many of them combine pleasingly with a crest or monogram. If a special design is desired, our Designing Department will gladly submit sketches for your approval.

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Gas is used only for starting the fire. Rubbish and garbage provide fuel. The drying of the garbage is accomplished by the heat of the burning rubbish, not by the heat from the gas. Complete combustion is assured through



the construction of the grate and the preheating of the air, which make possible the highest temperatures. The grate construction permits shaking of ashes into the pan without dumping any burned material.

This incinerator requires floor space of eighteen by twenty-four inches and stands three feet nine inches high.

Ultraviolet Generators

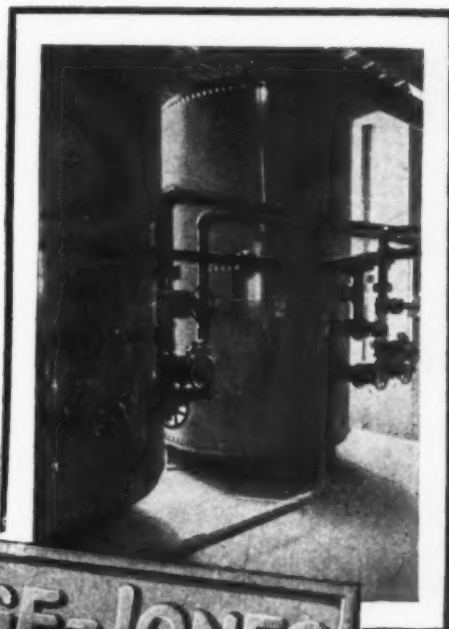
A new installation by which several treatments with longer regenerative ultraviolet wave lengths may be given simultaneously has been recently perfected. Treatment booths are arranged in pairs or in groups of four, and the air-cooled ultraviolet generator is suspended from overhead at a fixed height, so that dosage is measured by time exposure.

Obvious advantages of these installations are economy of time and effort on the part of the technician, as treatments are regulated by a single control cabinet. This fact is also responsible for a considerable saving in the cost of equipment. The installation was designed especially to serve in hospital physiotherapy departments and physiotherapy clinics.

Caring for X-Ray Equipment

By S. L. WARREN, M.D.
Department of Radiology, Strong Memorial Hospital,
Rochester, N. Y.

X-ray equipment should be installed in such a manner as to have all of the machinery in a soundproof and dust-proof cabinet, with as short an overhead, high-tension circuit as possible from this cabinet to the tube stand and radiographic table. This will reduce materially the care of this type of equipment, and will eliminate to a great extent the necessary repeated cleanings, with the accompanying expense due to repairs from wear of machinery



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How Softened Water Will Provide Funds for Needed Equipment

Your laundry can benefit as did this commercial laundry

"... we felt that if we saved one-fourth of the cost of our supplies we would be well satisfied. Having used this installation (Paige-Jones) for eighteen months, we are very happy to let you know that we have saved fifty per cent of our supply cost."

Cleveland Sanitary Wet Wash Co., Cleveland, Ohio.

CURRENT supplies and replacements are items that no hospital can avoid. But their burden on the treasury can be greatly lightened.

Take the laundry for instance—soap and other supplies can be reduced from $\frac{1}{3}$ to $\frac{1}{2}$; or the linen room, if the life of linens could be greatly lengthened, replacements would naturally drop; or take coal for the power plant and boiler tube replacements, both can be greatly decreased.

The savings thus made available

can then be used for other needed equipment and supplies.

Softening the water does the trick.

How to do this and at the lowest possible cost is told in an instructive bulletin—Softened Water, The Universal Need. Make it a point to write *today* for a copy.

**PAIGE & JONES CHEMICAL
COMPANY, Inc.**

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PAIGE & JONES WATER SOFTENING

~ ZEOLITE AND LIME SODA SOFTENERS ~ PRESSURE SAND FILTERS ~
~ BOILER FEED WATER TREATMENTS ~

Need Money for a New Building?

Every hospital has in its executive positions trained specialists. Such persons accomplish more in less time than others.

The same principle applies to raising money. Specialists raise more money most economically.

Hedrick, Marts & Lundy offer the experience of a number of men who have successfully raised money in many cities from the Atlantic to the Pacific. They have obtained large sums for new hospitals, for additions to old equipment—or to clear off accumulated debt.

"Financing Philanthropy" quarterly paper, free on request

Campaigns undertaken anywhere. All the many details are carefully directed by our experienced staff.

Tell us your plans.

HEDRICK, MARTS & LUNDY, Inc.

Member Joint Board of Campaign Counsel and Planning
527 Fifth Avenue New York

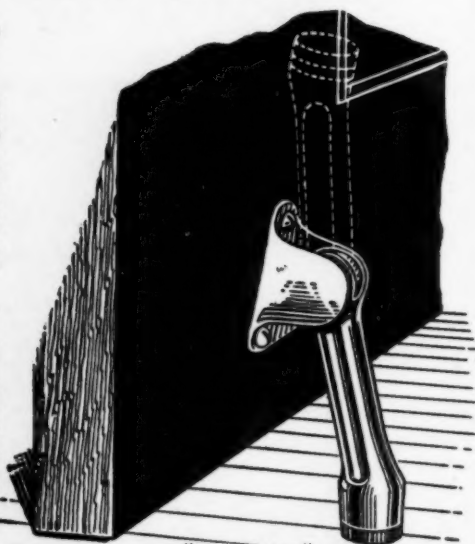
A SILENT EFFICIENT DOOR HOLDER

Cast Bronze construction.

All finishes.

Equipped with tough rubber shoe — lasts indefinitely. When necessary to replace shoe, simple to insert another without removing device from door.

Will not mar floor or tear carpets. Easily operated with foot, fool proof with no mechanism to get out of order. Operates perfect in connection with door closers holding the door open at any desired degree in a positive manner.



"HERCULES"
GLYNN-JOHNSON CO.

WRITE FOR DESCRIPTIVE LITERATURE
SAMPLES SUBMITTED UPON REQUEST

Glynn-Johnson Corporation
La Porte, Ind.

District Offices and Representatives in All Principal Cities

exposed to this dust. All wiring should be put in cables or conduits and kept off the floor. This eliminates danger of accident to the operator and patient, and makes it impossible for the scrub woman to wet cables left on the floor, with resultant danger of short circuit.

Radiographic tables should have casters on them to facilitate their removal. This makes the unit much more flexible, as the beds can be substituted for the radiographic table when very sick patients are being examined. The cleaning problem is also greatly simplified by this arrangement.*

Deep therapy equipment should be established with the safety of the operator and the patient particularly in mind. All machinery should be enclosed in soundproof and dustproof cabinets or rooms, to which no one has access but the operator. All equipment should be off of the floor on wooden insulating bases. All wires should be laid in conduits. This will simplify the cleaning problem and avoid the chance of water collecting around the base of the equipment when floors are scrubbed, with danger of short circuit to ground.

The treatment tube should be put in a couch, permanently installed in place with all high tension wires completely insulated from the patient. The structure with the tube and high tension and filter equipment makes a permanent insulation, which is easy to take care of and needs relatively little cleaning. There is no danger of an employee breaking a tube or other equipment. As a general rule, all cleaning of rectifying switches, high tension switches and overhead systems should be attended to by the x-ray service man for the local district. Ordinary cleaning people might jar something out of place, with resultant injury to tubes or danger to the operator or patient, so that this type of personnel should never be used for this sort of work.

Hangers should always be available to keep spare tubes out of harm's way. Cabinets should be conveniently placed, so as to care for sinus boards and other equipment necessary for radiographic and treatment work. This will aid in keeping the radiographic rooms neat in appearance.

The handling and drying of films in the developing rooms should be done as much as possible by mechanical means in order to save time and labor. Developing films in large numbers and drying them in racks with warm air under pressure greatly increases the efficiency of the dark room.

Solving Food Delivery Problems

By B. E. HEDDING, M.D.

National Home, Wis.

All hospital superintendents appreciate the difficulties encountered in the constant effort to serve palatable food to the sick. Much time is devoted to this problem and we can conservatively estimate that 45 per cent of the hospital budget is expended for the upkeep of the dietary department. The serving of unpalatable food to the sick continues to be the chief cause of complaint from patients, and is the cause of anxiety to those responsible for this service.

Even if the raw food purchased is the best the market affords, and even if the preparation is carried out under the supervision of a trained dietitian the necessary time consumed in transferring it under methods of delivery now in vogue brings the finished product to the patient frequently cold and unpalatable. The fault is not in the purchasing and preparation but in the delivery.

Announcing!

An Achievement in Small Dish Washing Machines

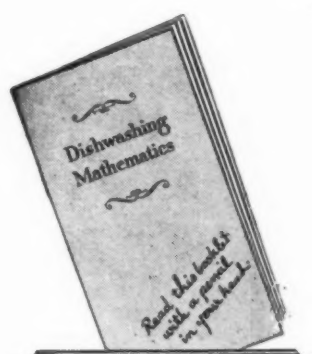


MODEL "O" is the latest addition to the Champion line. That it ably meets the demand for a practical, low-priced, small Dish Washer is evident from the following partial list of its features:

1. PRICE: \$290—lowest priced Dish Washer on the market.
2. SIZE: requires minimum floor space—table level height—no superstructure.
3. LOCATION: may be set anywhere, flush in corner if desired, as it feeds from the top.
4. OPERATION: simplest—controlled by one lever only.
5. CONSTRUCTION: extremely simple yet sturdy; made entirely of cast iron, except lid, which is cast aluminum.
6. STERILIZATION: steam sprays above water level rather than mixing steam with washing water.
7. RINSE SPRAY: solid spray rather than the usual hollow, conical spray.
8. ADAPTABILITY: when not in operation it can be used as a sink.
9. FINISH: gray Duco enamel—attractive finish that does not soil easily.
10. MOTOR: sets in niche beneath machine—absolute protection.

Send for particulars regarding this triumph in Dish Washing machines.

CHAMPION DISH WASHING MACHINE COMPANY
HOBOKEN, NEW JERSEY 1358 Builders Bldg., Chicago



Institutional Managers may receive a copy of "Dishwashing Mathematics" upon request. This book contains simple formula for determining the washing costs of your tableware.

Built like a Battleship!



CHAMPION

Dish Washing Machines

Your patients voted Kellogg's ALL-BRAN 100% effective

NEARLY seven thousand people, scattered throughout the country, were asked for their experience with Kellogg's ALL-BRAN. To 96% of those answering, ALL-BRAN brought complete and permanent relief from constipation. 68% of these people had previously tried and found part-bran products comparatively ineffective.

A remarkable verdict from an impartial jury! ALL-BRAN affords prompt relief to sufferers from constipation. And more than that—prevents its recurrence.

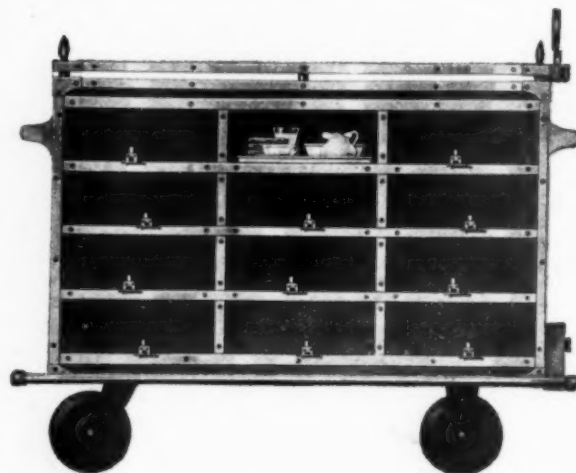
Kellogg's ALL-BRAN supports the aims of the modern medical profession. An appetizing health cereal that supplements the diet. When eaten regularly with milk or cream, with fruits added, with other cereals, or in cooking, ALL-BRAN supplies the bulk necessary to proper elimination of the intestinal tract.

Made by Kellogg in Battle Creek, Michigan. Sold by all grocers. Served everywhere. In the red-and-green package.

Kellogg's
ALL-BRAN

A method assuring the delivery of food to the patient in approximately as good condition as it left the range would solve the problem and bring appreciation in place of complaint. Hospital executives are not indifferent to this matter, but are giving constant thought to the correction of faulty food delivery and admit that some correction must be made if this department is to be up to standard.

Centralized kitchen service, meaning the setting up and serving of trays in the main kitchen, under the super-



vision of the dietitian, and the conveying by mechanical means of the several trays directly to the patient, offer the best solution so far presented. If it is possible to keep the served food hot and moist while being transferred from kitchen to patient, this system will overcome most of our food difficulties.

A conveyor that insures a better food service to bed patients in hospitals and sanatoriums, and provides the missing link for centralized diet kitchen tray service, that is, distribution direct from kitchen range to patient without loss of original heat and flavor has been found in a device recently put on the market.

The conveyor is an insulated metal container on wheels, ball bearing throughout, divided into twelve separate tray compartments closed by individual pivoting doors, and heated by means of a hot water circulating system. The body of water in the base radiator is brought to the desired temperature by the use of electric heating elements, the current being supplied from any ordinary lighting or motor wall socket.

The circulation of the hot water throughout the cart insures a uniform and constant heat, and through an ingenious device, necessary humidity within the compartments is maintained. The insulation is such as to retard the loss of heat to the greatest possible degree, permitting delays in the time for tray distribution without deterioration in the quality of the food.

The conveyor is fitted with a water thermometer recording the heat of the water in the reservoir, a water level indicator, and a device for the control of the expansion accompanying the heating of the water.

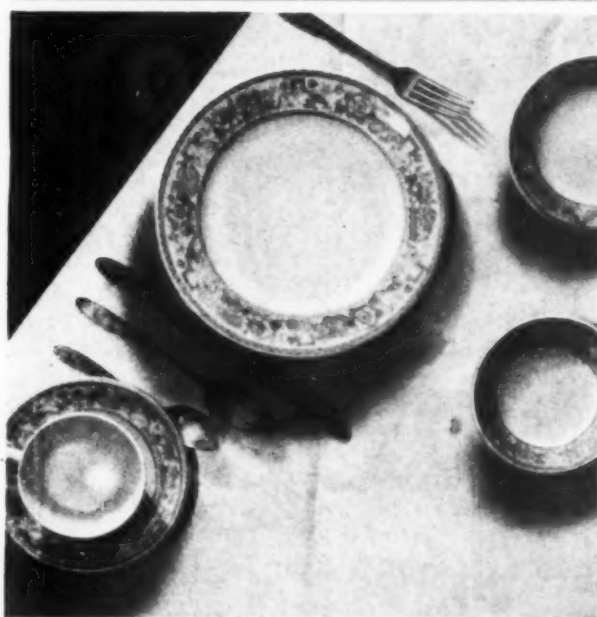
An accessory cold food section, with doors on either side, is available for closed container requirements, and can be lifted on and off the conveyor unit. The conveyor is fitted with rubber-tipped bumpers to protect the conveyor itself when in motion and also the doors and walls of the hospital building. The weight of the conveyor insures steadiness in its operation and fairly steep inclines are negotiated without spilling of liquid food. A single attendant operates a loaded conveyor with ease.

This Nationally Known Hospital uses Nationally Known Syracuse China

The leading hospitals in the country find nothing that excels Syracuse China in beauty, durability and charm. Because of the excellence of its equipment you naturally would expect to find the name of the Chester County Hospital, West Chester, Pa., on the list of Syracuse China users.

Syracuse China is just right in weight. Its famous rolled edge prevents it from readily nicking and chipping. A high glaze assures the

permanence of its beautiful designs. It is hand-fired, thoroughly vitrified, genuine china—meeting every sanitary requirement of modern hospital practice. See a Syracuse dealer near you. Ask him to show you our standard patterns and samples of made-to-order work.



ONONDAGA POTTERY
COMPANY
Syracuse, New York
58 E. Washington St.,
Chicago
551 Fifth Avenue,
New York



SYRACUSE CHINA

Your patients will eat milk

when you cannot coax them
to drink it!

Big or little, patients with the most uncertain appetites respond to junket. It is easy to make junket look attractively appetizing, and for each day's serving entirely different. By varying toppings with fruits, whipped cream, or white of egg you add still more to its high food value.

Milk served as junket is, as you know, even more nearly perfect as a food than it is in its natural state. In causing milk to coagulate, rennin—the active principle of Junket—performs the first step necessary for its perfect assimilation.

Junket Tablets are also invaluable in the preparation of infant foods such as Protein Milk and Whey. You will find authoritative information on infant feeding and therapeutic uses of junket in our booklet, "Junket in Dietetics"—free on request.

Junket Tablets, not sweetened or flavored, in packages of 100; Flavored Junket, sweetened, in pound cans, specially prepared for hospital use. Specify flavors desired:

Vanilla	Chocolate	Lemon
Orange	Raspberry	Coffee

Junket

REG. U. S. PAT. OFF.

THE JUNKET FOLKS

Chr. Hansen's Laboratory, Inc.

Dept. 74

Little Falls, N. Y.

In Canada,

Chr. Hansen's Canadian Laboratory, Toronto, Ont.



Book Reviews and Current Hospital Literature

Nutrition and Diet in Health and Disease

By JAMES S. McCLESTER, M.D., Professor of Medicine,
University of Alabama, Birmingham, Ala.¹

This is a comparatively complete survey of the more prominent measures employed at the present time in nutrition and diet therapy. The text is divided into parts and each part is subdivided into sections, having a logical arrangement and tabulations that make it an easy means of reference.

Part 1, "Nutrition and Health," includes in Section A, "The Need for Food and Its Utilization," the fundamental factors of nutrition, digestion and food requirements as they are accepted today. Section B, "Food Products," is a compendium of food materials in common use. In Section C, "Diet in Health," the normal diet for both children and adults is notably good, and a chapter by Dr. McKim Marriott is devoted to feeding of infants. Tables which are necessary for accurate work, and a few suggested menus and recipes add to the value of this section. The author stresses the importance of public instruction on this subject, and lists five groups of people who should feel responsible for giving this instruction. It seems strange to find dietitians not included in the list. Part 2, "Nutrition in Disease," presents a compilation of the available information and methods of practice in diet therapy.

To have such a fund of facts assembled in one volume will be helpful to the medical practitioner. The book is obviously written for the medical man and represents a medical man's point of view. This probably explains why Part 2 is more comprehensive and covers the "how" and "why" of methods, to a greater extent than is the case in Part 1.

Couriers of Mercy

Friendly Talks to Nurses

By EDWARD F. GARESCHÉ, S.J., General Spiritual
Director of the International Catholic Guild of Nurses.²

The latest book by Father Garesché is perhaps his best, and he has discussed with considerable skill the ethical duties of nurses as well as some details of nursing education. The spiritual side of nursing and the spiritual duties of the nurses are well treated as well as the more material duties. It is planned to create in the character of the nurse a love of her profession and a realization of its great possibilities. It is meant, too, to give her encouragement in the practice of her duties and to give her assistance in living up to her ideals of mercy.

¹ W. B. Saunders Company, Philadelphia, 1927.

² The Bruce Publishing Company, Milwaukee, Wis., 1928, \$1.50.



DISTINCTIVE

A dignified, efficient and distinctive method of marking hospital trays which appeals to the patient's sense of individuality and gives evidence that the institution is using care in keeping every patient's tray and napkin properly identified. It occupies but small space, fitting into the corner of the tray. It provides ample ring space with separate clip for the card. Holder is silver plated on hard white metal; very durable. Cards are specially printed with the name of your institution. Can be supplied in colors for special diets, if desired.

- 141-A-3—Silver holders, per doz...\$5.50
 141-A-4—Specially printed cards, white only, per 1,000.....\$3.00
 Additional thousands 2.25
 141-A-5—Specially printed cards, any color or assorted, per 1,000.....\$3.50

The above is a typical example of the many items in hospital service which have been designed by us to improve or economize hospital service.

Will Ross, Inc., offers a complete service in hospital supply, furnishing virtually everything but foods and drugs. If you are not using our catalogue regularly both of us are losing much. May we send you a copy?

A cellulose absorbent that has set new standards of quality, that has brought prices down, and is favored by hospitals because of the convenient way it is packed and the ease with which it can be handled and used. Cheaper, more absorbent and convenient than the best absorbent cotton. Supplied in two, five and sixteen pound rolls or in cut size. Prices on application.

Sanisorb

THE IDEAL ABSORBENT

WILL ROSS, INC.
 WHOLESALE HOSPITAL SUPPLIES
 459 E. WATER ST. MILWAUKEE

The New SEPTISOL Dispenser



Ten Important Advantages

- 1 The entire unit is neat and compact—nothing clumsy or bulky in the way or to interfere while washing.
- 2 The Septisol Dispenser is easily attached to any wall.
- 3 The absence of any valves or parts on the dispenser insures long satisfaction and steady service. The dispensing tube is adjustable to any position.
- 4 The soap container is glass—holds one quart of soap—handy to fill.
- 5 The flexible, metal tube permits foot plunger to be moved at will.
- 6 The foot plunger is portable—offers no interference in cleaning or mopping.
- 7 Slight pressure gives the correct amount of soap—simple but positive in operation—pneumatic pressure does the work.
- 8 These Dispensers are licensed, without cost, to users of Septisol Surgical Soap, the pleasing, efficient and highly concentrated soap for surgeons.
- 9 Septisol is economical. One gallon can be diluted with one to four gallons of water.
- 10 This new soap dispensing device protects the surgeon against possibility of infection, as is possible in exposed soap trays or receptacles.

Write for full details of the Septisol offer and interesting literature.

Vestal Chemical Co.
 St. Louis, U. S. A.



Trade Mark Reg.

To quicken interest in the breakfast tray~

*this dish that tempts
and nourishes*

Cream of Wheat With Poached Eggs

$\frac{1}{4}$ cup uncooked Cream of Wheat
4 cups boiling water $\frac{1}{4}$ tsp. salt
Poached eggs Butter, salt, paprika

THE resourceful dietitian or nurse must constantly contrive new and simple breakfast dishes to rouse the appetite of convalescents.

To do so, those in charge of menus in many leading hospitals are serving combination dishes like the one given above—a cereal base combined with eggs, or at other times, with fresh or stewed fruits.

The cereal they most often choose is one that is ideal for the purpose—Cream of Wheat. Its simple, granular form imposes no tax upon weakened digestive systems; its exceptionally high carbohydrate content insures nourishment.

Nurses find that new cereal combination dishes win patients' favor because they rouse appetite and interest. Dietitians know that physicians' orders on dietary requirements are being satisfactorily filled. At the same time they have provided an ideal food at a minimum cost, for Cream of Wheat has 40 generous servings at less than 1c each in every package. And almost every patient can eat Cream of Wheat in some form.

Many other delicious and practical recipes are in the free booklet, "50 Ways of Serving Cream of Wheat." Send for it today.



FOR THIRTY ONE YEARS A STANDARD FOOD ON
PHYSICIANS' DIET LISTS

Cream of Wheat

Cream of Wheat Company, Minneapolis, Minnesota
In Canada, made by Cream of Wheat Company, Winnipeg

© 1928, C. of W. Co.

NEWS OF THE HOSPITALS

California

Pomona City has a new health center, which, according to Dr. J. L. Pomeroy, county health officer, Los Angeles County, and head of the department under which the center operates, is modern and fully equipped. The cost of construction was \$68,000.

A four-story, fireproof structure is to be erected in East Oakland as a privately owned hospital. It will have a capacity of fifty beds and has already been leased for twenty-five years to a group of Oakland physicians.

Delaware

A gift of over \$200,000 has been received by the Physicians' and Surgeons' Hospital, Wilmington, toward the fund for the new nurses' home, from Irenne duPont, in memory of Dr. Albert Robin. The new home is to be known as "Robin Hall." Mr. duPont had previously given \$400,000 for the construction of the hospital, and \$100,000 to be set aside as a fund for possible emergencies.

District of Columbia

The new \$300,000 addition to the Georgetown University Hospital, Washington, is ready for occupation. The building is a five-story structure adding 128 beds to the capacity of the hospital. The basement is devoted to the dispensary service, and contains among other facilities, twenty-six clinical examination rooms, accommodations for infant welfare and prenatal work, correction of speech defects, and a social service department.

Georgia

The King's Daughters Hospital, Waycross, recently suffered a \$15,000 loss by fire. Twenty-five patients were carried to safety by nurses and firemen, while streams of water were being played on the burning section of the building to prevent a spread of the flames. A large amount of the hospital equipment was saved.

Illinois

The new Passavant Hospital, in which \$1,500,000 is being invested, is under construction on the McKinlock Campus of Northwestern University Medical School, Chicago.

Construction of additions, costing \$600,000, to the Blessing Hospital and St. Mary's Hospital, both of Quincy, is under way and it is expected that they will be completed by Fall.

Massachusetts

The nurses' home, in connection with the New Salem Hospital, New Salem, has recently been completed. The building represents an investment of \$360,000 and is equipped to house 100 nurses.

Michigan

The U. S. Marine Hospital, Detroit, is to have a new four-story building to replace the old structure, which was erected before the Civil War. The new building will

For Infants— Carnation Milk

An unmistakable tendency of the times is the growing acceptance by pediatricians of *unsweetened* evaporated milk as a *superior* form of cow's whole milk for use in infant-feeding formulas. Unsweetened evaporated milk (of which Carnation is the largest selling brand) is simply cow's whole milk in approximately double concentration, as the following table shows.

	WATER	FAT	PROTEIN	MILK-SUGAR	MINERALS
Evaporated Milk	74.4%	7.8%	6.9%	9.4%	1.5%
Cow's Whole Milk	87.0%	4.0%	3.3%	5.0%	0.7%

Note: Do not confuse *unsweetened* evaporated milk with sweetened condensed milk. The latter contains about 43% cane sugar. Evaporated milk may be reconstituted as whole milk of normal richness by the addition of an approximately equal volume of water.

The following advantages of Carnation Milk may be noted:

- 1 It is easier to digest than boiled or pasteurized milk. A very fine, soft curd is formed, due to sterilization and the homogenization of the butterfat.
- 2 The fat-soluble vitamins A and D and the B vitamin are not injured. Only the antiscorbutic vitamin C is impaired: formulas are supplemented as usual with orange or tomato juice.
- 3 The milk is already completely sterilized—free from all bacteria.
- 4 It is a satisfactory source of calcium, phosphorus, and nitrogen, slightly superior to pasteurized milk.



You can dilute the double-rich contents of the tall can until the quart bottle overflows with pure, rich milk. Carnation is also furnished in gallon cans for large users.

5 It is constant in quality and uniform in richness.

6 It may be used in routine feeding throughout the year. It is especially valuable in the preparation of lactic-acid formulas.

In addition to its value in infant feeding, Carnation fills an important place in the economy of main hospital kitchens. It produces superior cooking results, makes possible material savings, and makes easy the maintenance of adequate reserves against any emergency. Write and ask us to tell you more specifically how Carnation Milk might render valuable service in your hospital.

CARNATION MILK PRODUCTS COMPANY

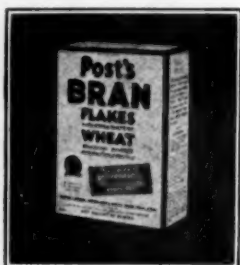
410 Carnation Bldg., Oconomowoc, Wis.

510 Stuart Bldg., Seattle, Wash.

New York

Aylmer, Ont.

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For balance in the diet

In addition to supplying natural bulk and arousing keener interest in food, Post's Bran Flakes provides such essential elements as iron, phosphorus, proteins, carbohydrates and vitamin-B.

Doctors and nurses find Post's Bran Flakes a natural bulk food that is an efficient corrective of constipation. Patients find it a crisp, delicious cereal even when their appetites are most bored.

Postum Company, Inc.

Dept. B-2948, Battle Creek, Mich.

We shall be glad to send to any physician or nurse a sample of Post's Bran Flakes, and samples of other Post Health Products, which include Post's Bran Chocolate, Grape-Nuts, Post Toasties and Instant Postum. If you live in Canada, address Canadian Postum Company, Ltd., 812 Metropolitan Building, Toronto 2, Ontario.

POST'S BRAN FLAKES

WITH OTHER PARTS OF WHEAT

as an ounce of prevention



accommodate 135 patients and will be thoroughly equipped with all modern features, including x-ray and facilities for light treatments. The hospital will be of simple colonial architecture. It is to be built during the Spring and summer and will be ready for occupancy by Fall. The old building and site will be sold at auction by the government upon completion of the new structure.

Minnesota

Contracts have been awarded for the construction of an addition to the Fairmont Clinic, Fairmont. The new building will be a three-story brick building costing about \$90,000. Work is to be started soon.

Interest on the gifts of William H. Eustis, to the University of Minnesota Medical School, Minneapolis, to provide for the care of crippled children, has added nearly \$600,000 to the original sum. This money is to be used in the construction of a new hospital building on the East River. This building will include a hospital for the care of crippled children, a dispensary and a student health service.

A new nurses' home for St. Mary's Hospital, Minneapolis, is to be constructed this Spring. The new unit will house 200 nurses who are at present living in near-by homes and in the hospital. It is expected that the new building will cost in the neighborhood of \$400,000.

A new building for the Neuropsychiatric Hospital of the Northwest, Minneapolis, is to be built this Spring by Dr. W. A. Jones, owner of the institution. It will be a four-story building containing fifty beds and will cost \$200,000.

Missouri

The Southeast Missouri Hospital, a four-story building, located at Cape Girardeau, has recently been dedicated. The building, which has sun parlors, recreation rooms, laboratories, a nurses' home and other conveniences, cost \$150,000.

Nebraska

Announcement has been made of the opening of the Belle Dewey Memorial Ward at the Nebraska Methodist Episcopal Hospital, Omaha. The main purpose of this ward is to offer free treatment to women patients afflicted with cancer.

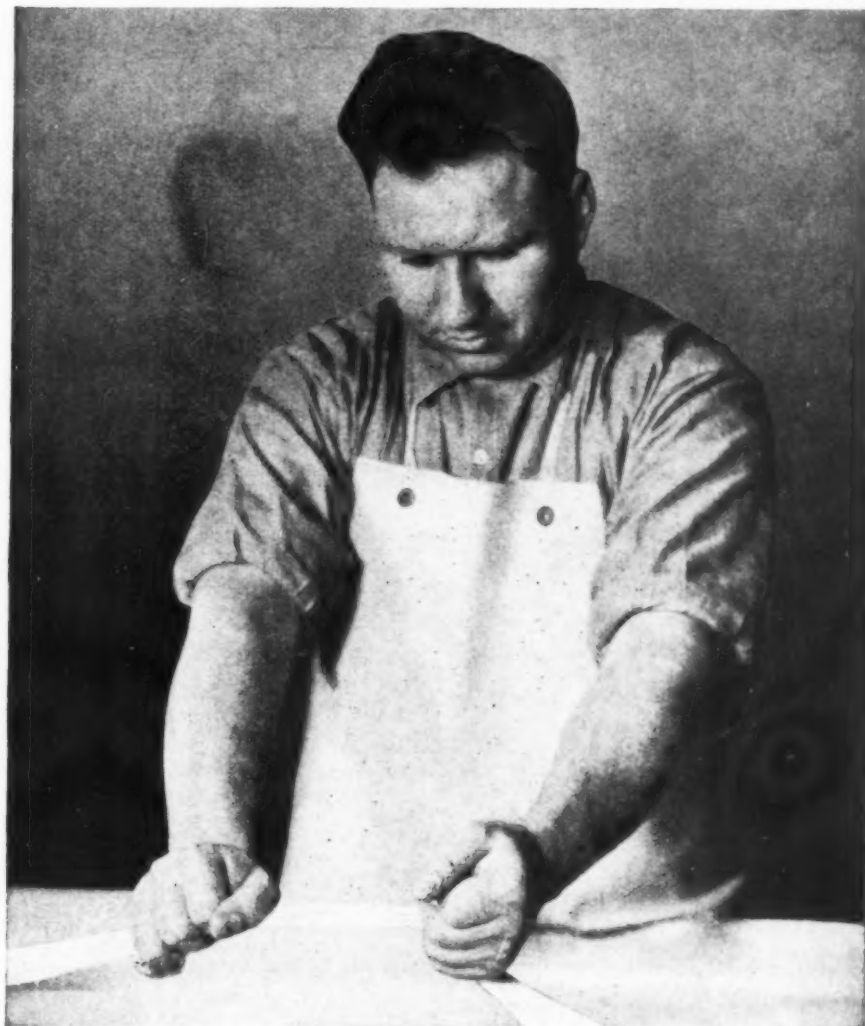
New York

The Metropolitan Hospital, Welfare Island, has established a new out-patient department for obstetrical cases at 430 East Eighty-eight Street. Prenatal and postnatal consultations will be included in the service.

The construction of a new addition to the Neurological Institute at the Medical Center, New York, is under way. The building will be fourteen stories high, containing 130 ward beds, a children's ward, fifty private rooms and thirty-five smaller, moderately priced rooms, to meet the needs of people of modest income. One entire floor and the roof garden will be devoted to therapeutic facilities, with special attention to occupational therapy.

Plans for a \$1,000,000 building program for 1928 have been made by the Beth Moses Hospital, New York. When the new buildings are completed, the bed capacity of the institution will have doubled. The realization of these plans will place the Beth Moses Hospital among the leading hospitals of the city. Nearly all the money required to carry out this program has already been subscribed by the directors of the institution.

*Work Portraits—*from the Ligature Department of Johnson & Johnson



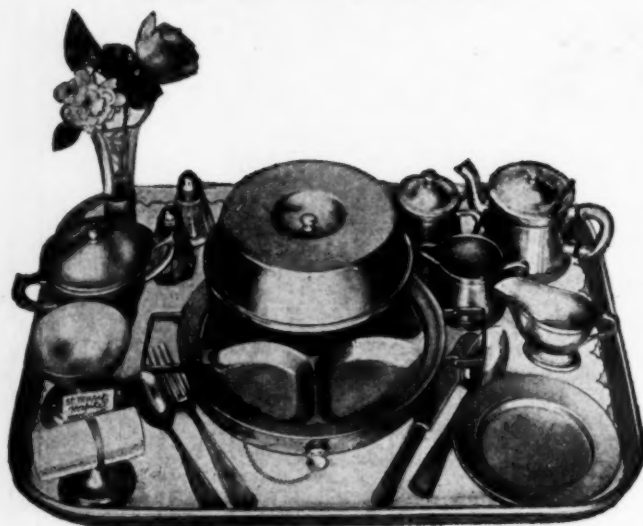
"Generations in Ligature Service"

MANY EMPLOYEES have spent years with this company.

The foreman, for instance, has been long trained in the manufacture of raw ligatures even as his father and grandfather were before him.

Write for the revised "Handbook of Ligatures." It is of interest to surgeons, nurses, students and superintendents.

THORNER'S Silver Service



Thorner's Silver Service is made of 18% Nickel Silver with a quadruple silver plate. Wears a lifetime. Replacement through breakage is forever eliminated. It is never affected by wear or polishing.

Illustration features Thorner's Improved Three Compartment Hot Water Plate. Tea Set with reinforced bands, hard metal hinges, Silver Soldered and one-piece unbreakable bottom. Covered Soup Cup with Silver Soldered handles. Sherbet Dish, Gravy Boat, Individual Napkin Ring and Tray Marker, Bud Vase, Salt and Pepper Shakers and Superior Grade Sectional Plate Flatware.

THORNER BROTHERS

*Importers and Manufacturers of
Hospital and Surgical Supplies*

**386-390 Second Avenue
NEW YORK CITY**

Catholic Hospital Assn. Exhibit, Cincinnati Music Hall, Cincinnati, Ohio. June 18th to 22nd. Booth No. 43.

University of Chicago to Offer Summer Courses in Nursing

The University of Chicago will offer four courses in nursing during the summer quarter of 1928. The quarter will be divided into two terms, the first running from June 16 to July 25 and the second from July 26 to August 31. The first term will include three courses devoted to the subjects of public health nursing, supervision in public health nursing, and supervision in schools of nursing. The fourth course, to which the second term is entirely devoted, is teaching of the principles and practice of nursing.

The university has engaged as instructors Cecelia Evans, R.N., formerly director of the bureau of public health nursing of the State Board of Health of Wisconsin; Dorothy Rogers, A.M., R.N., assistant professor and assistant director, Washington University School of Nursing, and assistant superintendent of nurses, Barnes Hospital, St. Louis, Mo., and May Kennedy, B.S., R.N., director, Illinois State School of Psychiatric Nursing. Various health agencies, hospitals, and schools of nursing in the city of Chicago have offered their cooperation in promoting the success of these courses.

New Jersey Hospital Association to Meet in May

The New Jersey Hospital Association has changed the dates of its annual meeting to Friday and Saturday, May 25 and 26, in order that this meeting may not conflict with the convention of the American Nurses Association at Louisville, Ky. The New Jersey Hospital Association meets this year at Atlantic City.

Discuss Erection of Prison Hospital for Narcotic Patients

A bill has been introduced in Congress by J. J. Cochran, St. Louis, providing for the construction and equipment of a building to be used as a United States narcotic prison hospital. In his argument for the construction of such a hospital, Mr. Cochran stated that investigation has shown him that during the past ten years there has been a 110 per cent increase in the population of federal prisons, and that if a narcotic hospital is not built it will be necessary to construct another federal penitentiary. According to Mr. Cochran, there are, at the present time, 2,116 prisoners serving sentences for violation of the Harrison Narcotic Act. Of this number it is estimated that 2,000 are addicts, and the remainder have been convicted for illegal traffic in narcotics.

Minnesota Dietitians Meet

The March meeting of the Minnesota Association of Hospital Dietitians was held at the Witt Market House, Minneapolis, Minn. A meat cutting demonstration, in which the choice cuts, and proper methods of carving were explained, proved to be an attractive feature of the meeting. After the demonstration, the Witt Market House was host to the association at a dinner.

JELL-O answers the hospital dessert question—*deliciously!*

PARADISE CHARLOTTE

(This recipe makes 75 one-half-cup servings. Use twice the ingredients to make 150 servings, etc.)

½ cup Instant Postum

1 gallon boiling water

1 26-oz. package Strawberry Jell-O
(Institution Size)

2½ cups sugar

¼ teaspoon salt

12 ounces marshmallows, cut in quarters

2 tablespoons vanilla

1½ quarts heavy cream, whipped

1 pound mixed nuts

Dissolve Instant Postum in boiling water. Add Jell-O, stir until dissolved, then add sugar and salt. Chill. When slightly thickened, whip with electric beater until consistency of whipped cream. Add vanilla to whipped cream and fold into Jell-O. Put nuts through coarse grinder and fold into mixture with marshmallows. Turn into mold. Chill until firm. Serve with whipped cream or custard.

THERE'S a recipe worth saving—and that's only one of many delicious Jell-O desserts! Jell-O can be combined with cream and fruits in dozens of ways. Served plain, it makes a clear and sparkling dessert, with wonderful flavors from fresh, ripe fruits. The Institution Size package makes a gallon of plain Jell-O—enough to serve from 40 to 50 persons, at a cost of little more than one cent per serving!

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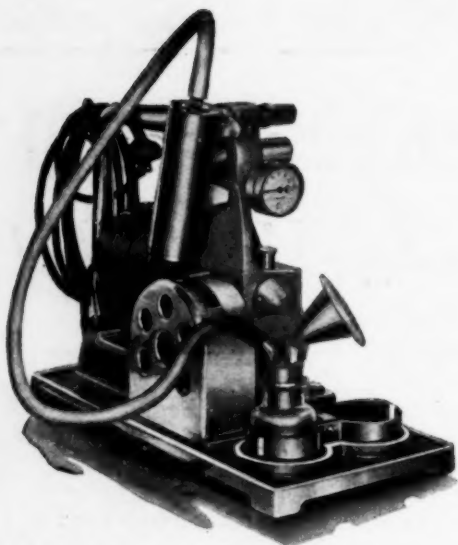
Besides a wide variety of desserts, delicious salads and entrees can be made with Jell-O, most economically, and easily. Dietitians recommend these dishes for everyone in the hospital—patients and employees both. Jell-O is very easy to digest and, in addition, it is a source of energy, and supplementary protein nourishment.

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PERFECTION ELECTRIC BREAST PUMP

Bill to Provide Fund of \$16,000,000 for Veterans Discussed

Hearings on the hospitalization program of the Veterans' Bureau, conducted by a subcommittee of the house committee on World War Veterans' Legislation in connection with the Luce bill (H. R. 5604), were concluded February 4 with the testimony of the director of the Veterans' Bureau, Brig. Gen. Frank T. Hines.

The bill authorizes an appropriation of \$16,000,000 for the establishment of new hospitals and the extension of existing facilities.

Two programs have been submitted to the subcommittee, one by General Hines and the other by the American Legion, approving the projects proposed by General Hines but suggesting additional facilities.

The Hines program, originally providing 2,040 beds for neuropsychiatric patients, 480 for tuberculosis patients and 400 for general medical and surgical patients, was increased as the result of the suggestion made to the committee by General Hines on February 4.

Upon statements from members of the committee that facilities for the care of neuropsychiatric patients at St. Louis and vicinity were inadequate, General Hines proposed the addition of 175 beds to the hospital at Excelsior Springs, Mo.

He also explained that proposed extension of 100 beds to the general medical and surgical facilities at Fort Oglethorpe, Ga., near Atlanta, could be increased to 200 beds. Suggestion also was made for the expenditure of \$500,000 at Fort Lyon, Colo.

As originally submitted to the committee, the program of General Hines called for the expenditure of more than \$10,500,000, while the Legion program more nearly approached the \$16,000,000 which would be authorized by the Luce bill. With the three additions put forward by General Hines on February 4, the two plans are more nearly alike.

At the suggestion of Edward McE. Lewis, representing the American Legion, General Hines told the committee of a tentative agreement reached by the Veterans' Bureau and the Legion for the purchase, at \$53 an acre, of not more than fifty acres of land owned by the Government and adjoining the Veterans' hospital at Legion, Tex.

The land to be purchased by the American Legion of Texas is to be used for a community development to provide houses for families of the patients in the hospital.

Two Providence Hospitals Are Expanding

On March 7, 1928, members and the public were invited to inspect the west wing of the Homeopathic Hospital, Providence, R. I. This wing was built several years ago but was not finished until recently. It provides accommodation for sixty-nine patients, sixty-six in rooms for two beds, and contains three rooms for isolation purposes. One, possibly two floors will be used for nurses until a nurses' home is built. The nurses' home will probably be built in the near future.

St. Joseph's Hospital, Providence, has plans for a 100-bed addition. It will be six stories in height and will form the west wing of the present building. Three floors will be occupied by patients, and the other three floors will be devoted to out-patient work, provision for officers, x-ray laboratory and operating facilities.